Greater Midlands Cancer Network
Skin Network Site Specific Group

SKIN NSSG

Constitution 2009

NSSG Constitution – Agreement Cover Sheet

The constitution has been agreed by:

Position: Chair of the NSSG
Name: Dr Vivek Mudaliar
Organisation: Shrewsbury and Telford Hospital
Date agreed: 25th November 2009

Position: Chair of the Network Board
Name: Mr Simon Conolly
Organisation: Telford & Wrekin PCT
Date agreed: 27th November 2009

Position: Chief Executives of Acute Trusts in the Network for IOG Implementation Summary (08-1A-202j)		
Name	**Organisation**	**Date Agreed**
Christine Hall (Delegated representative)	**University Hospital of North Staffordshire**	**28th December 2009**
Tom Taylor	**Shrewsbury & Telford Hospital**	**15th January2010**
Antony Sumara	**Mid Staffordshire Foundation Trust**	**20th January 2010**
David Loughton	**Royal Wolverhampton Hospitals**	**27th January 2010**
Nick Whear (Delegated representative)	**Dudley Group of Hospitals**	**22nd December 2009**
Wendy Farrington-Chadd	**Robert Jones & Agnes Hunt Orthopaedic Hospital**	**27th January 2010**

Position: Chief Executives of Primary Care Trusts in the Network for IOG Implementation Summary

Measure 1A-202j IOG Implementation Summary

Measure 1A -206j List of Skin MDTs, host hospitals and referring PCTs

Measure 1C- 113j Primary care Referral Guidelines

Name	Organisation	Date Agreed
Tony Collins (Delegated rep.)	Dudley PCT	18.01.10.
Lyn Millar (Delegated rep.)	NHS North Staffordshire	13.01.10.
Tina Cookson (Delegated rep.)	NHS Stoke on Trent	15.01.10.
Paul Tulley (Delegated rep.)	Shropshire County PCT	18.01.10.
Yvonne Sawbridge (Delegated rep.)	South Staffordshire PCT	15.01.10.
Simon Conolly	Telford & Wrekin PCT	27.11.09
Adrian Phillips (Delegated rep.)	Wolverhampton City PCT	15.01.10
Simon Hairsnape (Delegated rep.)	Worcestershire PCT	08.01.10.

Position: Specialist Commissioning Group Representative

Measure 1A-202j IOG Implementation Summary

Measure 1A- 209j Supra Network T-cell Lymphoma MDT for Total Surface Electron beam Therapy

Measure 1A- 210j Referral for Photopheresis

Name: Kieren Caldwell

Organisation WM Specialised Commissioning Team

Date agreed: 16th December 2009

Position: Trust Lead Cancer Clinicians Measure 1A- 204j Network Configuration of Teams Measure 1A- 211j Distribution of Clinics for Immunocompromised Patients with Skin Cancer		
Name	**Organisation**	**Date Agreed**
Christine Hall	**University Hospital of North Staffordshire**	**28th December 2009**
Rob Hatts	**Shrewsbury & Telford Hospital**	**8th January 2010**
Paul Hiley	**Mid Staffordshire Foundation Trust**	**14th January 2010**
David Rowlands	**Royal Wolverhampton Hospitals**	**7th January 2010**
Nick Whear	**Dudley Group of Hospitals**	**22nd December 2009**

Position: MDT Lead Clinician for Specialist Team Catchment Populations (08-1A-208j)		
Name	**Organisation**	**Date Agreed**
Mr Sukh Rayatt	**UHNS**	**14th January 2010**
Dr Graeme Stewart	**DGOH**	**30th December 2009**
Dr Simone Oliwiecki	**RWH**	**21st December 2009**

Position: Cancer Network Partnership Group Facilitator – agreement to provide additional user advice as and when required by the NSSG/Cross-Cutting Groups when only one user representative available
Name: Ann Lake
Date agreed: 15th December 2009

Position: Arrangements for Skin Cancer in Specific Anatomical Sites (08 1A 212j-217j)		
Name	**NSSG Chair**	**Date Agreed**
Dr Sanjay Vydianath	**Head & Neck**	**21st December 2009**
Mr. Trevor Hunt	**Colorectal**	**16th December 2009**
Mr. Richard Todd	**Gynaecology**	**29th December 2009**
Mr. Brian Waymont	**Urology**	**22nd December 2009**
Dr Richard Chasty	**Haemato-oncology**	**21st December 2009**
Dr James Wylie	**Sarcoma – GMOSS**	**22nd December 2009**
Dr Charles Candish	**Sarcoma – West Midlands**	**13th December 2009**
NSSG members agreed the Constitution on 25th November 2009		
Constitution review date: December 2010		

Contents

Glossary of Terms

Definitions

Acute Trust	Your local hospital grouping (may be one hospital, but is usually more than one), called acute because you are referred there for treatment beyond the scope of your GP
Annual Report	Document which demonstrates the activities of the NSSG during the last year
Audit	Evaluation of a particular aspect of service/ service delivery
Greater Midlands Cancer Network (GMCN)	Collective decision making by agencies such as NHS Trusts, Commissioners, PCTs and can include patents to deliver coordinated services across the patient pathway. An organisational model for implementing targets set out in the NHS cancer plan. Can provide a solution to combined groups problems and achieve and deliver improved cancer services within the whole of a cancer network.
Locality User Group	A group of users who work together in partnership to improve cancer services, both locally and nationall. There are currently six locality groups, Dudley, Wolverhampton, Wyre Forest, Mid Staffs, North Staffs, Shropshire & Mid Wales. Each meets within their local hospital areas.
Partnership Group	This is made up of a all chairs and vice chairs of the locality groups, Network Deputy Director, Lead Cancer Nurses and Facilitators
Primary Care Trust (PCT)	Is an administrative grouping of GP surgeries in an area, who at present are the buyers (commissioners) of NHS services for their population
Support Groups	A Group of patients and carers who meet together for the purposes of supporting and helping each other to cope with their experience of cancer.
User	Someone who uses or has used cancer services – as a patient, carer, relative or friend. They may also at times be a representative from a self-help or support group.
User Involvement	The involvement of users in any aspect of health service.
Work Plan	Document which outlines the work to be undertaken by the NSSG during the year

Initials

A.H.P.	Allied Health Professional. These consist of dieticians, physiotherapists, psychologists etc.
C.W.T.	Cancer Waiting Times
C.A.T.	Cancer Action Team
G.M.C.N.	Greater Midlands Cancer Network
W.M.C.I.U.	West Midlands Cancer Intelligence Unit
C.N.S.	Clinical Nurse Specialist
C.S.U.F.	Cancer Services User Forum
I.O.G.	Improving Outcomes Guidance
L.I.T.	Local Implementation Team
M.D.S.	Minimum Data Set
M.D.T.	Multi Disciplinary Team
N.H.S.	National Health Service
N.I.C.E.	National Institute for Clinical Excellence
N.S.S.G.	Network Site Specific Group
P.A.C.T.	Patient Advisory Cancer Team
P.C.T.	Primary Care Trust
P.P.I.	Patient and Public Involvement
S.I.F.	Service Improvement Facilitator
S.I.	Service Improvement
S.H.A.	Strategic Health Authority - an administrative body responsible for aspects of health services in an area. They often evaluate the performance of other bodies.
T of R	Terms of Reference

INTRODUCTION

The Skin NSSG is a multi-professional group made up of health professionals from organisations across the Greater Midlands Cancer Network covering a population of 2 million.

This document outlines the Skin NSSG Constitution and Terms of Reference and will be reviewed on an annual basis.

TERMS OF REFERENCE *(Appendix One pages 23-27)*

Membership – Measure 1A-201j

Core Membership		
Vivek Mudaliar	NSSG Chair	SaTH
Sukh Rayatt	Consultant Plastic Surgeon (MDT LC)	UHNS
Simone Oliwiecki	Consultant Dermatologist (MDT LC)	RWH
Graeme Stewart	Consultant Dermatologist (MDT LC)	DGOH
Sue Kelly	Consultant Dermatologist (MDT LC)	SaTH
Eleanor Lochee-Bayne	Associate Specialist (MDT LC)	MSFT
Gwen Rylands	Skin Cancer Nurse Specialist	UHNS
Tracy Beese	Skin Cancer Nurse Specialist	DGOH
Sue Morgan	Skin Cancer Nurse Specialist	RWH
Jane Davenport	Skin Cancer Nurse Specialist	SaTH
Lynne Moreland/Liz Spittal	Skin Cancer Nurse Specialist	MSFT
Dr Simon Reid	A GPwSI in skin cancer practicing in the community	SaTH
Barbara Pugh	Patient Rep	
Steve Brothwell	Patient Rep	
Sue Morgan	Nominated NHS Employee of the NSSG responsible for User and Carer issues and information	RWH
Simon Grumett	Member of NSSG responsible for ensuring recruitment into clinical trials is integrated into the NSSG	RWH
Laura Russell	Network Administrator	GMCN

Additional membership		
Jane Davenport	NSSG Service Improvement Lead	SaTH
Nicola Lane	A Radiologist from a Trust within the Network	
Vivek Mudaliar	A Pathologist from a Trust within the Network	SaTH
Tom Jemmett	Network Cancer Information Group Manager	RWH
Joan Jackson	Member of the Network Executive Team	GMCN
Murray Brunt	Clinical Oncology Representative	UHNS
Simon Grumett	Medical Oncology Representative	RWH
Pauline Boyle/Linda Higgins	GM Cancer Research Network Representative	GMCN
Wayne Jaffe	Plastic Surgery Representative	UHNS
Doraisami Mohan	Plastic Surgery Representative	DGOH
Susan Kelly	Dermatologist	SaTH

DGOH: Dudley Group of Hospitals Trust
RWH: Royal Wolverhampton Hospital Trust
UHNS: University Hospitals of N. Staffordshire Trust
GMCN: Greater Midlands Cancer Network
MDT LC: MDT Lead Clinician
MSFT: Mid Staffordshire Hospital Trust
SaTH: Shrewsbury & Telford Hospital Trust

The group will be deemed to be quorate if there is clinical representation from 4/5 trusts

The Skin NSSG will have a Chair elected from within the membership of the NSSG.
The Chair will have an annual review with the Network Medical Director on 12th February 2010. ***(Appendix Eight, page 100)***

One of the NHS employed members will be nominated as having specific responsibility for user issues and information for patients/carers

A member of the NSSG responsible for ensuring that recruitment into trials and other well designated studies is integrated into the function of the NSSG.

Extended membership - the group will identify and recommend membership of other appropriate professionals as required, to achieve the objectives of the group.

In instances where only one user representative is available, the Cancer Partnership Group has agreed to provide additional advice as and when required to the NSSG meetings. This advice would be sought through the named Cancer Partnership Group Facilitator.

The Network will provide administrative support to the NSSG – either through the Network Team Administrator or the Network Secretary.

Frequency of meetings

The group will meet will meet a minimum of 3 times a year. Notes of the meeting will be produced and attendance recorded.

Role and Function of Group

The role and purpose of the Skin NSSG is to improve the experience and outcomes of cancer care for Skin patients in the Greater Midlands Cancer Network. This involves consideration of strategies and plans for service improvement and service development across the patient pathway, incorporating all aspects of care at appropriate stages of the patient's journey. The aim is to achieve the best possible outcomes and best quality of life for all patients who use skin cancer services within the Network.

The Skin NSSG:

- Is the Network Board's primary source of clinical opinion on issues relating to skin cancer for the Network
- Is the Group with corporate responsibility, delegated by the Network Board, for co-ordination and consistency across the Network for policy, practice guidelines, audit, research and service improvement relating to skin cancer.
- Will consult with the relevant cross-cutting Network groups on issues involving chemotherapy, cancer imaging, histopathology and laboratory investigation and specialist palliative care; and with the Heads of Service on issues involving radiotherapy.

The NSSG will be accountable for discharging their responsibilities to the Cancer Network Board. The Chair of NSSG may be required to attend Board meetings to discuss specific issues and/or present the views of the group as and when appropriate. Members of the NSSG will be responsible for feeding back information/decisions from the NSSG to their clinical and managerial colleagues.

The GMCN Cancer Commissioning Advisory Group has just been established and the Skin NSSG will develop a commissioning advisory role in conjunction with the GMCN CCG and will be the group's primary source of information pertaining to the development and commissioning of skin cancer services across the Network.

The responsibilities and core business of the NSSG can be expressed under six broad headings, which are contained within the Manual of Cancer Service Standards:

1. **Service Planning**
2. **Service Improvement/Redesign (Modernisation)**
3. **Service Monitoring and Evaluation**
4. **Workforce Development**
5. **Research and Development**
6. **Annual Report and Work Plan**

SCOPE OF SERVICE

IOG Implementation Summary (Measure 1A 202j) (*Appendix Two –pages 28 - 42)*

Please note when the IOG Action plan originally published , Walsall was part of the GMCN . This is no longer the case and Walsall skin patients do not flow into this Network

The IOG was published in 2005 and recommends four tiers of services – primary care, locality, specialist and supra-network.
The IOG makes clear recommendations that community based skin cancer services can only operate where there are clear training and governance links to hospital based skin cancer MDTs/services.

Only one locality (2 PCTs) has declared a Model 2 community based skin cancer service in GMCN. This is the Shropshire Locality and consists of Shropshire County PCT and Telford & Wrekin PCT.

The rest of the GMCN PCTs have commissioning arrangements that all services will be provided by their Acute Trusts

The two Network specialist MDTs are to be based at UHNS and Dudley/Wolverhampton (Black Country sMDT), where the specialist surgical service is provided through the plastic surgeons. Rare skin cancers are referred to Birmingham for management. The Network has no current plans to provide a Melanoma MDT (MMDT).

Provision of Skin Cancer Services in the Community – Measure 1A 203j

Policy for the provision of Skin Cancer Services in the Community

NHS organisations within GMCN have agreed that NHS provided skin cancer service delivered within a community setting will conform to one of the the acceptable service models contained within the Manual for Cancer Services 2008: Skin Measures

Policy Statement:
NHS Organisations forming the Greater Midlands Cancer Network are agreed that any NHS provided skin cancer services delivered within a community setting within GMCN will conform to one of the acceptable service models as detailed within the Manual for Cancer Services 2008: Skin Measures
PCTs may choose not to provide any NHS community provided skin cancer services

Network Training Policy for Skin Cancer Services in the Community
08-1C-116j

Document Title	**Network Training Policy for Skin Cancer Services in the Community**
Document Date	November 2009
Document Purpose	This document describes the arrangements for the provision of training for community skin cancer services and criteria for community skin cancer practitioners
References: Guidance & competencies for the provision of services using GP's with Special Interest (GPwSIs) D of H 2007	
Consultation Process	Consultation was with the Skin Network Site Specific Group and the Network Commissioning Group
Review Date (must be within three years)	November 2012
Approval: Network Site Specific Group Clinical Chair	

Scope of the Guideline

This document describes the arrangements for the provision of training for community skin cancer services and criteria for community skin cancer practitioners including GPs with special interest or model 2 practitioners.
Named trainers/assessors agreed with the NSSG and MDT will be provided. This will be a core dermatologist or a surgical member of the skin cancer MDT.

In Greater Midlands Skin Cancer Network, treatment for skin cancer in the community is only provided by acute trust clinicians in UHNS, RWH, and DGOH who are already MDT members within their Trust.
SaTH has a number of practitioners that fulfil this function and are undertaking accreditation to continue to treat skin cancer patients. They are listed within SaTH skin cancer guidelines and operational policy and spend time working alongside the acute clinicians. The agreed assessor is: Dr S Kelly
Mid-Staffs Foundation Trust is in the process of training a GPwSI who will then be accredited to treat skin cancer patients. The agreed assessors are: Dr A Ward and Dr N Hardwick
PCTs are required to inform the Cancer Network whenever a new provider of community skin cancer services is engaged.

- PCTs will ensure that any new service providers (practitioners) satisfy the relevant accreditation criteria. (Appendix 1)
- General Practitioners with Special Interests (GPwSI) and model 2 practitioners practising in the network should:

a) Each be associated with one named Local Specialist MDT (LSMDT) or Specialist Skin MDT (SSMDT).
b) Undergo 15 hours CPD in skin cancer per year.
c) Have one session per year with a consultant dermatologist who is a core member of a LSMSDT or a SSMDT.
d) Have their community skin cancer practice included in a NSSG agreed network-wide audit.

e) Attend four meetings of the MDT per year including two audit meetings.
f) Keep a personal log of at least 40 surgical procedures for potential skin cancer per year.

3. **Monitoring of Community Practitioners**

a) Monitoring of GPwSI is the responsibility of the PCTs.
b) The lead clinician of the LSMDT will monitor GPwSIs adherence to model 2 practitioners requirements related to the MDT.

4. **Skin cancer training for clinicians working in the community**

Training for clinicians newly working in the community
(This section is different for those already in community practice)

- 1 session per week of training with a consultant dermatologist or other
- member of the LSMDT in a skin cancer clinic for 6 months.
- Practitioners should be trained in skin surgical competencies according to the SS1 and SS2 specifications of the DH guidelines. Practitioners performing skin surgery hold the ultimate responsibility for the procedure undertaken.
- Maintain a Log book e.g. http://www.rcplondon.ac.uk/files/shorecordform.pdf

To record :

- Appropriate patient assessment (blood thinners etc)
- Obtaining of consent
- Appropriate patient information given (written and verbal)
- Appropriate use of local anaesthetic
- Procedures
    - observed (twice)
    - performed (twice)
    - performed and end result approved (twice)
- Appropriate use of topicals
    - 5 fluorouracil
    - Diclofenac
    - Imiquimod
- Record of 5 unusual or interesting cases seen in hospital or practice
- Attendance at a minimum of 4 LSMDT meetings
- Perform and present an audit to the LSMDT
- Procedures:
    - cryotherapy
    - punch biopsy
    - excision
    - shave excision
    - curettage and cautery

- DOPS (Directly Observed Procedures)
- For all procedures to be signed off by supervising consultant or core member of LSMDT and kept in log book.
- Attendance at a minimum of 4 LSMDT meetings and any at which their cases are discussed (recorded in log book)
- Attendance at network, regional or national skin surgery course (recorded in log book)

5. Maintenance of Skills (for all clinicians working in the community)

- Log book to record minimum of 40 surgical interventions for potential skin cancers per year (from the 5 procedures listed above).
- Annual prospective audit of excision margins or other relevant topics as identified in locality governance arrangements (to be recorded in log book).

- Attendance at network, regional or national skin course every 2 years (to be recorded in log book).
- Annual attendance for one session at of training with a consultant dermatologist or other LSMDT member in a skin cancer clinic (Sharing of skills / Buddying Arrangement). Must include hospital clinic at least every second year and DOPs for procedures undertaken signed off by supervising consultant or core member of LSMDT.
- Reciprocal arrangement for one session of training per year to be offered for LSMDT member in their skin cancer clinic (Sharing of skills / Buddying Arrangement).
- Attendance at a minimum of 4 LSMDT meetings per year, including 2 meetings at which audit is discussed.
- Compliance with locality governance arrangements

6. Training for Experienced practitioners

It is recognised that there are already a national pool of competent clinicians who could be exempt from the minimum training outlined above. An experienced practitioner is someone who has been an established service provider for a minimum of one year, complied with governance arrangements and participated in audit. The practitioner would need to demonstrate this in line with the timescales published in national guidelines for accreditation of GPwSIs and PhwSIs. Exemption may be conferred by the practitioner and verified by the lead clinician of the MDT.

For clinicians already in community practice DOPs on the following should be signed off by the supervising consultant or core member of the LSMDT and kept in the log book.

- Appropriate patient assessment (blood thinners etc)
- Obtaining of consent and appropriate patient information given (written and verbal)
- Appropriate use of local anaesthetic
- Cryotherapy
- Punch biopsy
- Excision
- Shave excision
- Curettage and cautery

7. Suggested prospective audits for clinicians working in the community

- Referrals to comply with Two Week Wait Guidelines for suspected cancer
- Patient feedback
- Numbers of procedures and type
- Infection rate
- Satisfactory excision margins
- Recurrence rate
- Conversion rate of excision to cancer diagnosis

8. Primary Care Referral Guidelines

Where Community Practitioners are not accredited to undertake skin cancer services, then the primary care referral guidelines should be adhered to:

a) Patients with actinic keratoses and precancerous lesions may be dealt with by any GP.

b) GPs should refer suspected cases of skin cancer requiring treatment, including suspected BCCs, to their local skin cancer MDT.

If the lesion is a suspected melanoma or SCC an urgent 2 week wait referral form should be completed.

9. Monitoring of the Guideline

Implementation of the guidance will be considered as an audit topic by the NSSG.

Appendix 1: Assessment tools

It is expected that, as part of the accreditation process, the assessment of individual competencies will include observation of clinical practice. The recommended clinical assessment tools are the modified mini-CEX (mini clinical examination) and DOPS (direct observation of procedural skills). The following notes are intended to support the effective use of these assessment tools.

- It is strongly recommended that a series of clinical assessments using a modified mini-CEX take place four times during the year of training prior to the GPwSI becoming accredited.

- Each clinical assessment is expected to take the equivalent of one session and should be performed by a consultant dermatologist, ideally an alternative to the training consultant.

- The assessor is expected to be present throughout the session and to make assessments, covering different clinical domains, from a number of patient interactions.

- Several modified mini-CEXs covering different areas are expected to be performed during each of the clinical assessment sessions.

- The subject/areas covered will depend on the type of service the dermatology GPwSI is going to offer. This will be agreed at the start of the training.

- The assessment outcome will be 'satisfactory' or 'unsatisfactory'. Time will be allocated for feedback.

- It is expected that one of the assessments should include a review of case notes and, for those offering a surgical service, a review of histology reports (to consider appropriateness of procedure, completeness of excision etc).

- It is expected that GPwSIs will need training in the recognition and management of conditions normally seen/managed in secondary care and that this knowledge will be acquired via continuing medical education.

- Logbooks – there will be other competencies that are not included but desirable; these can be documented in the GPwSI logbook and signed off by the trainer. This will probably differ for the individual GPwSIs and the detail will need to be agreed with the trainer at the beginning of training.

- For GpwSIs not completing a diploma, it is envisaged that an MCQ will be required in due course; at the moment this is not available. In the meantime, studying for a diploma in dermatology provides a good opportunity for structured learning.

- Clinicians will be expected to demonstrate evidence of 360-degree review using approved tools, for example BAD 360 degree appraisal tool.

- The DOPS tool will appropriate for the assessment of practical skills during the DOPS assessment sessions.

- Helpful general and speciality-specific guidance for the use of DOPS and the mini-CEX can be found a the following link: www.jchmt.org.uk/assessment/performanceAssessmentDocs.asp

Network configuration of teams (Measure 08-1A-204j)
Specialist team catchment Population (Measure 08-1A-208j)

Local Hospital Skin Multidisciplinary Teams and referral services into the LSMDTs and into the Specialist Skin MDTs.

The Specialist MDTs at UHNS and DGOH/RWH act as Local MDTs for their constituent populations

Table 1

Locality	Trust	Local Diagnostic Teams/MDTs Lead Clinician	Specialist MDT	Referring PCTs	Catchment Population
Northern Staffordshire	University Hospital of North Staffordshire Trust	**MDT location:** City General Site **Lead Clinician:** Mr Rayatt Consultant Plastic Surgeon **MDT frequency:** weekly **Facilities and Services**: Care Levels 1- 4 **Referral to MDT via:** GPs and General Surgeons	**Network Specialist MDT** **MDT Frequency:** Fortnightly Care levels 1-4 as LSMDT Care Level 5 as SSMDT **Population**: 880,000 **Referral to MDT via:** Dermatology/Plastic surgeons **Video-conference MDT from Jan. 2010:** weekly **Referring PCTs:** NHS NS, NHS SoT, SSPCT (portion) and MCPCT (portion)	NHS North Staffordshire NHS Stoke on Trent	461,600
Mid Staffordshire	Mid Staffordshire Foundation Trust	**MDT location:** Stafford Hospital **Lead Clinician:** Dr Lochee-Bayne Associate Specialist **MDT frequency:** weekly **Facilities and Services**: Care Levels 1- 4 **Referral to MDT via:** GPs and General Surgeons		South Staffordshire PCT	250,000

Locality	Trust	Local Diagnostic Teams/MDTs Lead Clinician	Specialist MDT	Referring PCTs	Catchment Population
Wolverhampton	Royal Wolverhampton Hospital Trust	**MDT location:** New Cross Hospital **Lead Clinician:** Dr Oliwiecki Consultant Dermatologist **MDT frequency:** weekly **Facilities and Services**: Care Levels 1- 4 **Referral to MDT via:** GPs and General Surgeons	**Joint Network Specialist MDT** **MDT Frequency:** Fortnightly Care levels 1-4 as LSMDT Care Level 5 as SSMDT **Population**: 750,000 **Referral to MDT via:** Dermatology/Plastic surgeons **Video-conference MDT from Jan. 2010:** weekly **Referring PCTs:** WC PCT, D PCT and SS PCT (portion)	Wolverhampton City PCT	236,800
Dudley	Dudley Group of Hospitals Foundation Trust	**MDT location:** Russells Hall Hospital **Lead Clinician:** Dr Stewart Consultant Dermatologist **MDT frequency:** weekly **Facilities and Services**: Care Levels 1- 4 **Referral to MDT via:** GPs and General Surgeons		Dudley PCT	306,500
Shropshire & Telford	Shrewsbury & Telford Hospital Trust	**MDT location:** Royal Shrewsbury Hospital **Lead Clinician:** Dr Kelly Consultant Dermatologist **MDT frequency:** weekly **Facilities and Services**: Care Levels 1-4 **Referral to MDT via:** GPs and General Surgeons		Shropshire County PCT Telford & Wrekin PCT Powys Health Board	510,600

Supra-Network MDT:
Care level 6 – Total Surface Electron Beam therapy (TSEBT) to University Hospitals of Coventry & Warwick and Referral for Photopheresis to Rotherham and London

GMCN have defined the levels of care to be provided at each MDT as follows:

LSMDT	Care Levels 1 – 4
SSMDT	Care Level 5
Supra-network MDT	Care Level 6

Total Surface Electron Beam therapy (TSEBT) to University Hospitals of Coventry & Warwick and Referral for Photopheresis to Rotherham and London

Network Configuration for the Community Skin Cancer Services
Measure 08-1A-205j ***(See separate documentation)***

PCTs within GMCN have clarified their commissioning arrangements in respect of Community Skin Cancer Services.

Network agreed referral patterns between named PCTs and LSMDTs
Measure 08-1A-206j

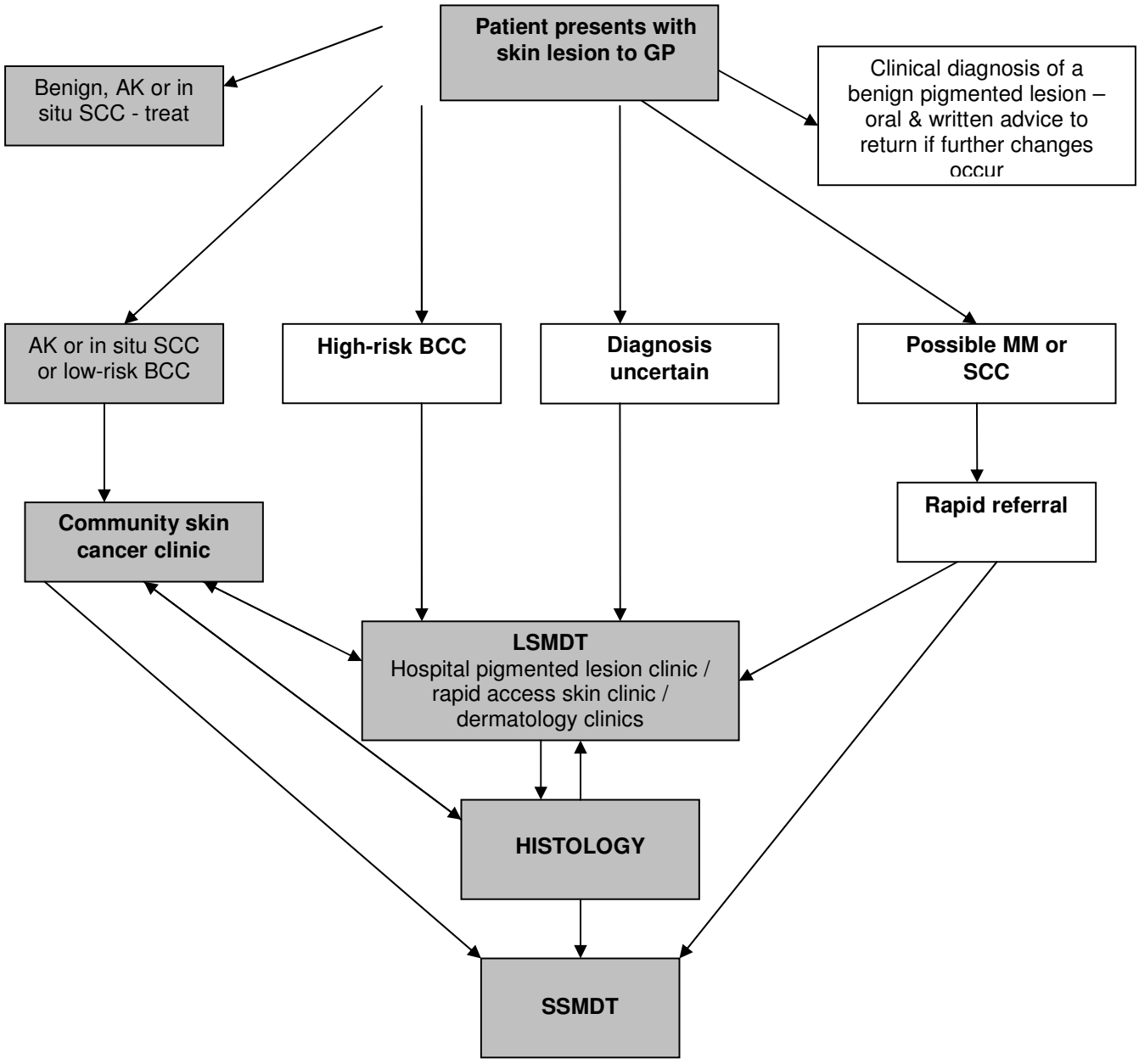
Please see table 1 on page 15 which clarifies the location of Local Skin MDT and principal referring PCTs.

Referral Guidelines between Teams Measure 08-1A-207j
See Schematic overleaf and definitions in table 1 (page 15)

Named practitioners for MOHS Surgery Measure 08 – 1C – 114j
The agreed and named prartctioners and averaged case numberers agreed by the NSSG Chair
(Appendix Seven page 101)

GMCN Skin Cancer Referral Pathway

Skin Lesion – patient pathway



DATA COLLECTION Measures 08-1C-103j, 08-1C-104j *(Appendix Three pages 48 - 49)*

The Skin NSSG has agreed to collect data in line with The Royal College of Pathologists minimum dataset 2002. The second edition is currently in development and will be adopted by the NSSG when published. This dataset is as specified in the National Contract for Acute Services.
The Skin NSSG has agreed a Network-Wide policy, in conjunction with the MDTs, for the data collection. It is the responsibility of all local MDTs to collect the MDS on all newly diagnosed Skin malignancies in their unit.

This data should be collected in electronic format through the Somerset Cancer Register.
The MDS comprises data fields covering:

- Patient demographics
- Cancer waiting time data
- Going Further on Cancer Waits
- Cancer Registry MDS
- Cancer Registry MDT dataset

The NSSG will regularly monitor the performance of each MDT against national cancer waiting time targets and will review the quality and completeness of data against national CWT targets, recommending corrective action where necessary. Data will be reviewed on a six monthly basis at an NSSG meeting.

Service Development Measure 08-1C-109j

The NSSG will ensure that local service planning for the development of cancer services is in line with national and local policy guidance and service standards. Key documents are:

- National Cancer Plan
- Cancer Reform Strategy
- NICE Improving Outcomes Guidance
- NICE Technology Appraisals
- The Manual of Cancer Services Standards

The NSSG will ensure that service planning:

- considers the whole care pathway for patients
- promotes high quality care and reduces inequalities in access and service delivery through agreed clinical and referral guidelines
- takes account of the views of patients and carers
- takes account of the opportunities for service/workforce redesign
- is consistent with an agreed model between the network and commissioners

The Skin NSSG Service Delivery Plan 2009 – 2012

The Service Delivery Plan shown below describes the short and medium term priorities for improvement and development of Skin cancer services in the Greater Midlands. The Service Delivery Plan will be reviewed and revised to incorporate the findings and recommendations of the Peer Review of Skin services due to take place in March 2010.

Service Development	Timescale	Responsibility
Continue to develop the role of Somerset Cancer Register (SCR) in the collection of the cancer MDS	2009 onwards	NSSG MDT chairs Network Leads
Work with Network Patient Partnership group on improving the patient pathway / patient experience	2009 - ongoing	NSSG
Consideration of a possible development of a Moh's service within GMCN	March 2012	NSSG MDTs/Trusts
Clarify, formalise and standardise pathways into specialist skin services	2009 - 2010	NSSGs Local Clinical leads
Review 2010 Network and Locality peer review reports and support delivery of associated remedial action plans. Use to inform future service development priorities.	From June 2010	NSSG Network Board Local Skin Clinical Leads Locality Groups
Continue to develop and extend network-wide standardised patient information pathways / information prescriptions	Ongoing	NSSG / MDTs
Develop Commissioning Advisory role in conjunction with GMCN Cancer Commissioning Group.	2009 - ongoing	NSSG/CCG
Review new treatments / modalities to inform Commissioning investment and priorities	2010	NSSGs Local Clinical leads

Service Improvement/ Redesign (Modernisation)

The NSSG and its multi-disciplinary teams are committed to service improvement and redesign. The NSSG will develop high quality information for patients for use across the Network

Service Monitoring and Evaluation

Key responsibilities:

- The NSSG will agree at least one annual network-wide audit project for its MDTs. The NSSG will annually review progress of network audit projects.
  (Measure 1C 105j, 1C 106j) **(*Appendix Four pages 50 - 62)***
- Monitor progress on meeting national cancer measures and ensure all local MDT action plans agreed following peer review are implemented.
- The NSSG will agree the model patient pathway across organisational boundaries, supported by agreed referral guidelines and agree the membership and role of MDTs at the various stages of the pathway.

Workforce Development

Responsibilities include:

- To consider and make recommendations for the overall workforce requirements for skin cancer services.
- To consider the education and training needs to support the workforce.

Research & Development (Measure 1C 107j, 1C 108j) *(Appendix Five pages 63 to 72)*

The NSSG, in consultation with its MDTs and the Cancer Research Network's Lead Clinician, will agree a single list of clinical trials/studies, for which the MDTs should give priority for patient entry.

Annual Report and Work Programme (Measure 1C 102j) *(See separate documentation)*

The NSSG will produce an annual report and work programme.
The NSSG will annually review its Constitution and Terms of Reference

NETWORK CLINICAL AND REFERRAL GUIDELINES (Measures 1A 212j – 1A 217j; Measures 08-1C 110j – 1C 113j) *(Appendix Six pages 73 to 100)*

The NSSG will be responsible for developing Skin Network Clinical and Referral Guidelines and will ensure that the guidelines are reviewed every three years, unless new guidance becomes available earlier. The guidelines cover the treatment of: Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma and Lymphomas.

08-1A-209j Supra-network T-Cell Lymphoma MDT for Total Surface Electron Beam
The Skin NSSG has an agreed guideline for referral to the Supra-network T-Cell Lymphoma MDT for TSEB.

08-1A-210j Referral for Photopheresis
The Skin NSSG has an agreed guideline for referral for Photopheresis.

08-1A-211j Distribution of Clinics for Immunocompromised Patients Skin Cancer
The Skin NSSG has agreed guidance on distribution of clinics for immunocompromised patients with skin cancer

08-1A-212j Arrangements for Skin Cancer – Head & Neck
The Skin NSSG has an agreed guideline with the Head & Neck NSSG for the treatment of Head & Neck skin cancers.

08-1A-213j Arrangements for Skin Cancer – Anal and Peri-anal
The Skin NSSG has an agreed guideline with the Colorectal NSSG for the treatment of Anal and Peri-anal cancers.

08-1A-214j Arrangements for Skin Cancer – Female Genitalia
The Skin NSSG has an agreed guideline with the Gynae NSSG for the treatment of skin cancer of external female genitalia.

08-1A-215j Arrangements for Skin Cancer – Male Genitalia
The Skin NSSG has an agreed guideline with the Urology NSSG for the treatment of skin cancer of external male genitalia.

08-1A-216j Arrangements with Haemato-oncology teams for lymphoma involving skin
The Skin NSSG has an agreed guideline with the Haematology NSSG for the treatment of systemic/nodal lymphomas and primary cutaneous lymphoma.

08-1A-217j Arrangements with sarcoma MDTs for sarcoma involving skin
Guidelines have been submitted to West Midlands Sarcoma MDT and to Greater Manchester and Oswestry Sarcoma Service for agreement.

08-1C-110j Skin Network Wide Clinical Guidelines
The Skin NSSG has agreed Network Guidelines , which reflect the UK/British Association of Dermatologists guidelines for the treatment of BCC, SCC, MM and Lymphomas.

08-1C-111j Imaging Guidelines
The Skin NSSG has an agreed guideline for the imaging of Malignant Melanoma. Dr Nicola Lane, Consultant Radiologist at UHNS, is the nominated Network Skin NSSG Radiology representative

08-1C-112j Pathology Guidelines
The Skin NSSG has an agreed set of Pathology Skin Cancer guidelines as the Network-wide pathology guidelines. Dr Vivek Mudaliar, Consultant Histopathologist at SaTH is the nominated Network Skin NSSG Pathology representative

08-1C-113j Primary Care Referral Guidelines
The Skin NSSG has developed a set of Primary Care Referral Guidelines for primary care practitioners in the GMCN Network. The guidelines have been circulated to PCT Skin Cancer Commissioners and will be available on the Network Website , once live (January 2010)

Appendix One Measure:08-1A-201j

Terms of Reference
Greater Midlands Cancer Skin Network Site Specific Group

1. *Background*

The aim of Greater Midlands Cancer Network (GMCN) is to ensure that all patients served by the Network receive a uniformly high quality service, with equity of access to care irrespective of where they live, to ensure the maximum possible cure rates and best quality of life.

The Network aims to provide this care as close to the patient's home as is compatible with high quality, safe and cost effective treatment. Care will be provided in a fully collaborative multi-disciplinary, multi-professional and multi-agency setting in which all professional and administrative boundaries are invisible to the patient. Patients will be genuine partners in their care and treatment.

The Cancer Service Improvement Programme is a national programme which aims to look at services along a cancer patient's journey, redesigning care in collaboration with clinical teams to improve the patient's experience and to reduce unnecessary delays. The Service Improvement agenda should therefore be fully embedded in the Network site-specific tumour groups.

2. *Purpose*

The Skin Network Site Specific Group (NSSG) supports the overall aims of the Network. The group will ensure the development of best practice in the total management of Skin Cancer in accordance with the recommendations of the Greater Midlands Cancer Network Board, the Network Wide Governance and Operational Group, the Cancer Reform Strategy, national cancer standards and any other national guidance relating to a specific tumour type. The purpose of the group is to ensure a well co-ordinated, multidisciplinary approach which incorporates representatives throughout the patients care pathway. A consistent approach to the delivery of care, ensuring equity of access to high quality services by establishing common guidelines which include referral guidance throughout the Greater Midlands Cancer Network.
The group also provides a forum for the exchange of information and the development of collaborative working practices with patient and carers views taken into account in planning and reviewing priorities in Service Improvement plans presented by the NSSG to the Network Board.

3. *Accountability*

The Skin Site Specific Group is accountable to the Greater Midlands Cancer Network Board through the Network Governance and Operational Group. If any member of the group is unable to attend a meeting, they should nominate a representative who has the authority to make decisions and recommendations on their behalf. The nominated representative will name themselves known to the secretarial/administrative support, for details of attendance to be recorded correctly.

4. *Aims*

- To produce for peer review;
    1. NSSG Constitution
    2. NSSG Work Programme
    3. NSSG Annual Report

- To gain consensus on the most appropriate configuration of Skin cancer services across the Network and make recommendations to the Strategic Cancer Network Board and Network Governance and Operational Group.

- The NSSG should ensure decisions become integrated into constituent organisational structures and processes.

- To co-ordinate the implementation of national and regional policies with respect to the Skin cancer service ensuring the delivery of consistent, high quality standards of cancer care.

- To develop and agree local clinical guidelines and protocols drawn from evidence based national guidelines to include prevention, diagnosis, treatment and palliative care of all patients with Skin cancer covering:

    - Referral of patients
    - Clinical Management
    - Audit
    - Teaching

- To develop tumour site specific pathways and service provision, ensuring uniform standards of care are applied across the Network.

- To identify and prioritise gaps in Skin cancer service provision across primary, secondary, tertiary, community and palliative care including issues relating to training, staffing and resource implications to inform the local and Network service delivery plans.

- To ensure that the Service Improvement agenda is integral to the Skin tumour Network by ensuring targets and timetables are adhered to.

- To work within the framework outlined in the Network I M and T Strategy, with regard to the identification and agreement of appropriate datasets for the tumour group, working towards implementing common operational policies for effective and robust data collection and data management

- To set/agree performance targets and monitor the volume and quality of patient care against these targets – including the implementation of audit programmes, benchmarking against other Networks.

- To provide a data set to include cancer waiting times monitoring in line with current national priorities, stating what these national targets are.

- To monitor national measures and ensure action plans are agreed and implemented following peer review.

- To further develop clinical and laboratory research to standards of national and international excellence, ensuring that these services are both appropriately rationalised and adequately supported, and disseminate all findings.

- Agree research and development programme/common clinical trials.

- To act as a forum for discussion of new treatments and a source of advice to the relevant Primary Care Trusts on efficacy and effectiveness of new treatment and planning for future developments.

- To produce an annual report on the work of the group and its role in Clinical Governance and present the groups achievements together with areas of concern/difficulties to the Network Wide Governance and Operational Group.

- To promote excellent services for patients with cancer and their families and carers.

- To ensure services are evaluated by patients and carers.

- To co-ordinate the accreditation process for Skin cancer services as determined and time tabled by the NCAT, SHA and national policy

- Report any identified risks/untoward incidents to ensure learning is spread.

5. *Chairmanship and Role Expectation of members*

Site Specialist Group Chairs should be elected from within each group. The term of office should be for 2 years; after this the Chair should change or be re-elected.

The Chair will:

- Work with Greater Midlands Cancer Network Management Team to ensure all stakeholders representing the patient journey across the Network are involved and the group is multi-professional in nature.
- Be responsible for ensuring that recommendations made by the Skin tumour group are taken to the Network Governance and Operational Group and decisions made by the Cancer Network Board are implemented within the Network.
- Foster a Network approach to issues.
- Provide strategic leadership to the Network

NSSG members will:

- Be responsible for cascading information and advice to appropriate locality and Network groups.
- Discuss, agree and share best practice.
- Provide comprehensive, united support to the Skin Site Specific Group and/or Chair/Deputy Chair.

A member of the Network Executive Management Team will support the chair in the development of agendas and work programmes for the group

6. *Membership*

The Board should identify all clinicians and support services involved in Skin cancer management at both Centre and Unit level and ensure their involvement as appropriate. All members will organise a cover representative to attend meetings if they are unable to. The cover representative will make themselves known to the secretarial support for attendance records. A Service Improvement Facilitator from the Network Service Improvement team will be available to the NSSG for guidance and to aid the delivery of the current work plan/projects for service improvement. Details of the NSSG membership as at 24th June 2009 are as follows:

Essential (core) Named NSSG Membership

The MDT Lead Clinician from MDT within the Trust	**Named member**
UHNS – Trust MDT Lead	BT (until 0609)Sukh Rayatt
RWH – Trust MDT Lead	Simone Oliwiecki
DGOH – Trust MDT Lead	Graeme Stewart
SaTH – Trust MDT Lead	Sue Kelly
MSGH – Trust MDT Lead	Eleanor Lochee-Bayne
Core Lead Nurse from a MDT	
Nurse Representative –CNS UHNS	Gwen Rylands
Nurse Representative –CNS DGOH	Tracy Beese
Nurse Representative –CNS RWH	Sue Morgan
Nurse Representative –CNS SaTH	Jane Davenport
Nurse Representative –CNS MSFT	Lynne Moreland/ Liz Spittal
Named Chair from core Trust Lead and Nurse Lead.	
	Boon Tan (March 2008 - June 2009)
	Vivek Mudaliar (July 09 onwards)
2 User representatives	
	Barbara Pugh
	Steve Brothwell
NSSG Service Improvement Lead	
CNS - SaTH	Jane Davenport
A GPwSI in skin cancer practicing in the community	
	Simon Reid
Nominated NHS Employee responsible for User and Carer issues and information	
CNS -RWH	Sue Morgan
Member of the NSSG responsible for ensuring the recruitment into clinical trials is integrated into the NSSG	
RWH	Simon Grumett
Named Secretarial/Administrative support	Laura Russell

NSSG agreed additional membership

A Radiologist from a Trust within the Network	Nicola Lane
A Pathologist from a Trust within the Network	Vivek Mudaliar
Network Cancer Information Group Manager	Tom Jemmett
Member of the Network Management Team	Joan Jackson
Clinical Oncology Representative	Murray Brunt
Medical Oncology Representative	Simon Grumett
GM Cancer Research Network Representative	Pauline Boyle / Linda Higgins
Plastic Surgery Representative	Doraisami Mohan
Plastic Surgery Representative	Wayne Jaffe
Dermatologist	Sue Kelly

7. *Frequency and location of meetings*

The NSSG will meet a minimum of 3 times a year and a minimum attendance will be a clinical representative of 4 out of 5 trusts for the group to be quorate.

8. *Administrative Support*

The Greater Midlands Cancer Network Team office will provide administrative assistance to take minutes, book rooms and circulate agendas for meetings, if required. The venue will be agreed by the group.

Greater Midlands Cancer Network Medical Director
Date: 19th August 2009

Review Date: September 2010

Agreed:

Vivek Mudaliar	Simon Conolly
Chair of Skin NSSG	Chairman of GMCN Board

Appendix Two Measure:08-1A-202j

NHS

Greater Midlands Cancer Network

Implementing Improving Outcomes Guidance for People with Skin Tumours including Melanoma


NEWCASTLE-UNDER-LYME
STOKE-ON-TRENT
Biddulph
Leek
Kidsgrove
Cheadle
Keele
Market Drayton
Ellesmere
Oswestry
Wem
Eccleshall
Stone
STAFFORD
Newport
Rugeley
Penkridge
SHREWSBURY
Hednesford
CANNOCK
TELFORD
Shifnal
Welshpool
(Y Trallwng)
WOLVERHAMPTON
WALSALL
Much Wenlock
Church Stretton
Montgomery
Bridgnorth
Wombourne
DUDLEY
STOURBRIDGE
Craven Arms
HALESOWEN
KIDDERMINSTER
Bewdley
Ludlow
Tenbury Wells
Stourport-on-Severn
BROMSGROVE

April 2007

Foreword

Ensuring the quality of care for patients with skin cancers is one of the most important challenges facing the Greater Midlands Cancer Network (GMCN) today. The GMCN is committed, as demonstrated in this action plan, to ensuring patients have equity of access to a fast, fair and high quality service.

Our strategy for patients with skin cancers and their carers is based on the NHS Cancer Plan, Improving Outcomes Guidance (IOG), local needs and expertise and is integral to the delivery of accessible, effective patient-centred services.

The Greater Midlands Cancer Network is building upon an already sound infrastructure and through the provision of resources and change management approaches, we aim to provide the services our patients and carers need and reasonably expect. This is underpinned by sharing of knowledge and expertise through centrally facilitated routes of communication, training and education via the multidisciplinary team (MDT).

Implementation of the Improving Outcomes Guidance recommendations has been managed through the Network Site Specific Group (NSSG). The Network Board has committed to active monitoring of the implementation plan against the Improving Outcomes Guidance with regard to access, quality and outcomes. This will be achieved through the Network Governance Operational Group, which meets bi-monthly. Performance reports will be presented to the Network Board every 6 months.

We are delighted to present this action plan reflecting the Black Country and North West Midlands achievements and aspirations of the GMCN, embedded throughout the whole Network.

Martin Yeates Network Chair	**Damian Murphy** Clinical Director	**Ruth Serrell** Network Director
Date:		

Rob Lusuardi
WM Specialised Commissioning Date:

Jonathan Lloyd
Head of Performance
NHS West Midlands

1.0 Covering Summary

1.1 The Network

The Greater Midlands Cancer Network (GMCN) has been created by merging the Black Country and North West Midlands Cancer Networks to improve the management of the partnerships between primary, secondary and tertiary providers and the voluntary sector in the provision of services for people with cancer. Its core objectives are to ensure the provision of consistent, high quality and equitable services through strong leadership and management of national guidance.

The Network serves a catchment population of around 2.1 million people who live in the NHS West Midlands area and covers the following 9 Primary Care Trusts (PCTs):

Dudley PCT	304,000
North Staffordshire PCT	210,000
Powys LHB	50,000
Shropshire PCT	288,000
South Staffordshire PCT	327,000
Stoke on Trent tPCT	245,000
Telford & Wrekin PCT	161,000
Walsall tPCT	253,000
Wolverhampton PCT	239,000
Worcestershire PCT (Wyre Forest)	102,600

The Greater Midlands Cancer Network covers a population of c2.2m but its boundaries overlap with other cancer Networks. Referrals flow into the north of the Network from the central area of Central and Eastern Cheshire PCT, an additional 246k population.

There are 9 hospital sites and 8 acute Trusts:

Russells Hall Hospital, Dudley Group of Hospitals NHS Trust
Kidderminster Treatment Centre, Worcestershire Acute Hospitals NHS Trust
Manor Hospital, Walsall Hospitals NHS Trust
New Cross Hospital, Royal Wolverhampton Hospitals NHS Trust
University Hospitals of North Staffordshire NHS Trust
Staffordshire General Hospital, Mid Staffordshire Hospitals NHS Trust
Royal Shrewsbury Hospital, Shrewsbury and Telford Hospitals NHS Trust
Princess Royal Hospital, Shrewsbury and Telford Hospitals NHS Trust
Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Trust

1.2 The Action Plan

This paper sets out the action plan for the GMCN on the report Improving Outcomes Guidance in People with Skin Tumours including Melanoma, which was published in February 2006.

1.3 Process Overview

Following the publication of the IOG, the NSSG produced the action plan with key milestones and resources required for implementation of the recommendations. The plan has been agreed by the Network Board, Commissioners and the Strategic Health Authority.

1.4 Network Site Specific Group (NSSG)

The Skin Cancer NSSG comprises membership from the 8 acute trusts in the Network, a Primary Care Cancer lead and members of the Network team. The Group includes patient and carer representation. The group meets regularly to agree diagnosis and treatment guidelines, clinical trials, audit programme and provides advice to the Network on a number of issues when requested, e.g. service configuration and priority areas for development.

1.5 Patient & Public Involvement (PPI)

The GMCN has effective User and Carer Groups in each Locality with an overarching Network Partnership Group. The chair of this group sits on the Network Board. This is a strong platform from which the patient voice is heard and acted upon at all levels, e.g. Network Board, NSSGs, cancer centres and units. Further developments will involve patients and their carers through a number of routes, led by the Network Partnership Group.

1.6 Commissioning Process

The implementation of the IOG may result in increased costs for quality improvement in the service. The NSSG will develop a business case for any additional funding required and this will be submitted to the Commissioners through the Local Delivery Planning process.

1.7 Key Recommendations

Community skin cancer services

Networks to liaise with PCTs to agree service specification for community skin cancer services, ensuring governance arrangements in line with NICE IOG.

Formation of the local hospital skin cancer multidisciplinary team (LSMDT) and streamlined local referral services into the LSMDT

Networks are asked to agree their streamlined local referral services into the LSMDT. It is important that no more than one LSMDT is established at an acute hospital site. The IOG recommends LSMDTs should serve populations in excess of 200,000.

Formation of the specialist skin cancer multidisciplinary team (SSMDT)

The population referred to the SSMDT should be 750,000 or more. It is expected that most Networks will have only one SSMDT. If the Network proposal identifies more than one SSMDT, SCGs explicit agreement must be obtained and the rationale for two SSMDTs should be clearly laid out in the proposal.

Formation of supra Network teams to manage rare tumours

Agree supra Network services for rare skin tumours, cutaneous lymphoma, dermatofibrosarcoma protuberans (DFSP), merkel cell carcinoma or eccrine porocarcinoma, through the Specialised Commissioning Groups. Proposal to be submitted for each supra Network MDT by the appropriate SCG.

Arrangements for other special groups.
Specialised Commissioning Groups to agree proposals for the following special groups.

- *Transplant patients* - ensuring access to specialist transplant patient skin clinic. It is likely that specialist transplant patient clinics will need to be established in each of the transplant centres.
- *Patients with a genetic predisposition to skin cancer* – ensuring access to clinical genetics services or a specialised dermatology service (as outlined on page 118 of the skin IOG)
- *Children and young people with skin cancer* – ensuring liaison between the Skin and Children and Young People IOG implementation processes. Agreed arrangements should be set out in the final proposals for Children and Young People's services

2.0 Current & Future Service Provision

2.1 Current & Future Service Provision at Cancer Units (Diagnostic/Local Team)

Cancer Site	*Current Position*	Planned Position
Malignant Melanoma (MM)	Diagnosis, staging and surgery are undertaken locally	Diagnosis, staging and surgery to remain local when appropriate.
Non-melanoma skin cancers (NMSC)	Diagnosis, staging and surgery are undertaken locally	Diagnosis, staging and surgery to remain local when appropriate.

2.2 Current & Future Service Provision at Cancer Centre (SMDT & Supra-Network)

Cancer Site	Current Position	Planned Position
Malignant Melanoma (MM)	As above	Patients to be discussed at Network MDT and management agreed Appropriate resectional centre to operate on all patients.
Non-melanoma skin cancers (NMSC)	As above	Patients to be discussed at Network MDT and management agreed Appropriate resectional centre to operate on all patients.

2.3 Designated Diagnostic/ Local Multi Disciplinary Teams by PCT

Malignant Melanoma

Name of Hospital/ MDT	Name of Trust	Referring PCTs
Manor Hospital	Walsall Hospitals NHS Trust	Walsall PCT
New Cross Hospital	The Royal Wolverhampton Hospitals NHS Trust	Wolverhampton City PCT South Staffordshire PCT Dudley PCT Walsall PCT
University Hospital of North Staffordshire	University Hospital of North Staffordshire NHS Trust	North Staffordshire PCT Stoke on Trent tPCT
Royal Shrewsbury Hospital	Shrewsbury & Telford Hospital NHS Trust	Shropshire County PCT Telford & Wrekin PCT Powys LHB
Russells Hall Hospital	Dudley Group of Hospitals	Dudley PCT
Staffordshire General Hospital	Mid Staffordshire Hospitals NHS Trust	South Staffordshire PCT

Please see paragraph 1.1 for PCT populations.

Non-Malignant Melanoma

Name of Hospital/ MDT	Name of Trust	Referring PCTs
Manor Hospital	Walsall Hospitals NHS Trust	Walsall PCT
New Cross Hospital	The Royal Wolverhampton Hospitals NHS Trust	Wolverhampton City PCT
North Staffordshire Royal Infirmary	University Hospital of North Staffordshire NHS Trust	North Staffordshire PCT Stoke on Trent tPCT
Royal Shrewsbury Hospital	Shrewsbury & Telford Hospital NHS Trust	Shropshire County Telford & Wrekin PCT Powys LHB
Russells Hall Hospital	Dudley Group of Hospitals	Dudley PCT

Staffordshire General Hospital	Mid Staffordshire Hospitals NHS Trust	South Staffordshire PCT

Please see paragraph 1.1 for PCT populations

NB: All patient pathways are developed to allow for cross flow of patients between units and centres to take account of patient choice.

2.4 Formation of Specialist Skin Cancer MDT (SSMDT)

Name of Specialist Skin MDT	**Host Trust for SSMDT**	**Referring PCTs**
Skin Oncology MDT, Selly Oak Hospital, Birmingham (Dr Jerry Marsden)	***UHB Foundation Trust***	***Shropshire County PCT Telford & Wrekin PCT Powys Local Health Board South Staffordshire PCT Walsall PCT***
For very large Networks where SCGs explicit agreement has been agreed to more than one SSMDT: ***Three LSMDTs (North Staffordshire, Wolverhampton and Dudley) currently do not refer out of the Network*** ***The NSSG wishes to develop two SSMDTs within the Network*** ***This is due to existing expertise available within the Network*** ***The population served by the Network*** ***The geographic constraints of the Network*** ***The location of the 2 SSMDTs has to be agreed*** **The final agreement on SSMDT(s) will need to reflect the audit proposal results regarding the identification of the future Network Block Dissection Leads**		
Final Milestone Date **confirming establishment of SSMDT(s)** ***December 2009, following Audit analysis***		

2.5 Location of block dissection surgery

Name of SSMDT surgeon	Confirmed minimum 15 block dissections per year (groin or axilla)	Location of hospital where all block dissections will be undertaken
SEE BELOW		
Final Milestone Date when surgeons will be performing at least 15 block dissections per year at an agreed hospital location: ***None of our Network surgeons or Pan Birmingham Cancer Network (PBCN) surgeons currently undertakes a minimum of 15 block dissections.*** ***GMCN, in parallel with PBCN, intends to undertake a prospective audit on block dissections performed during 2007/2008 to include outcome measures.*** ***Following analysis of the results, a decision will be made as to the future referral pathways to appropriate surgeons within the two Networks.*** **Advice is being sought from DH re Gynae and H&N block dissection overlap at the request of the Network Medical Director.** ***The proposed date for implementation is December 2009.***		

2.6 Location of supra Network MDT for T-cell cutaneous lymphoma

Specialised Commissioning Group:

Name of supra Network MDT for T-cell cutaneous lymphoma	Host Trust for supra Network MDT	Referring SSMDTs
Lymphoma Clinic, Selly Oak Hospital* ***St Johns, Rotherham**** ***Leeds General Infirmary**** **** as appropriate***	***UHB Foundation Trust*** ***Rotherham*** ***Leeds***	***To be agreed as per 2.4***
Final Milestone Date confirming establishment of supra Network MDT ***This will be dependent on the milestones identified within the relevant Network Action Plans***		

2.7 Location of supra Network MDT for B-cell cutaneous lymphoma

Specialised Commissioning Group:

Name of supra Network MDT for B-cell cutaneous lymphoma	**Host Trust for supra Network MDT**	**Referring SSMDTs**
Lymphoma clinic Selly Oak Hospital, Birmingham	***UHB Foundation Trust***	***To be agreed as per 2.4***
Final Milestone Date confirming establishment of supra Network MDT ***This will be dependent on the milestones identified within the relevant Network Action Plans***		

2.8 Referral Arrangements

The GMCN NSSG for Skin Cancers has established referral and management guidelines derived from the recommendations of the IOG. These include a Network-wide patient pathway.

3.0 Actions required to ensure compliance with Improving Outcomes Guidance

	Process Steps	Action	Responsibility/ Lead	Timescale	Comments/Progress
1.	The demographic profile & expressed needs of the service should be scoped	• Identify PCTs covered by Network & populations • Patient & User	Network Team Network Team	Compliant Compliant	

2.	Audit appraisal of current service	• Scope current service against IOG requirements, including:
		  • Dermatoscopy available in all MDTs
		  • Moh's surgery available in each Network
		  • All radiology departments to have access to high quality medical photography & storage of digital images
		  • Treatments using surgery and carbon dioxide laser techniques available at regional centres
			Network Team	Compliant	

3.	Service specification for community skin cancer services	• Agree, with PCT representatives, service specification for community skin cancer services, ensuring governance arrangements in line with NICE IOG and following published guidance to accredit clinicians who will treat low risk basal cell carcinomas in the community.	NSSG Chair / Network Medical Director/ DND	Awaiting national guidance for detail March 2009	Potential impact of time needed on education and mentoring of GPs
4.	Register identifying accredited clinicians who will treat low-risk basal cell carcinoma (BCCs) in the community.	• Develop register	PCT leads	March 2009	Potential impact of time needed on education and mentoring of GPs

5.	Agreed clinical guidelines for the management of precancerous lesions by GPs		NSSG Lead Clinicians	March 2009	Potential impact of time needed on education and mentoring of GPs
6.	Doctors and nurses with special interest working in the community are approved by and accountable to the lead clinician for the local skin cancer multidisciplinary team (LSMDT/SSMDT) and the relevant individual in the PCT		Lead Clinicians / PCT Leads	Once Service Specification and Register in place and approved - March 2008	Potential impact of time needed on education and mentoring of GPs
7.	All doctors and nurses with a special interest attend at least four MDT meetings a year, of which at least two are audit sessions with an educational component	• Monitor attendance at MDT meetings • Programme of meetings to include audit	L/SSMDT Leads / NSSG Audit Lead	March 2009	We would expect any clinicians treating low risk BCCs in the community to comply with IOG guidelines i.e. fulfil training requirements of a GPwSI or be based in the Dermatology department. They should also have had further training specifically in Minor Skin Surgery
8.	Processes for onward referral of cancer cases in line with IOG to local LSMDT, supported by agreed Network clinical protocols/guidelines		NSSG Chair / Lead Clinicians	March 2008	
9.	Quality assurance	• Develop programme of quality assurance, including training and maintenance of skills for clinicians working in the community	PCT Leads / NSSG	March 2009	
10.	Agree clinical alert processes (between LSMDT/SSMDT Lead and PCT) where community care is delivered outside of agreed clinical governance arrangements		LSMDT/SSMDT/ PCT Leads	March 2009	

11.	Local and specialist MDT	• Agree 2 levels of MDT: local and specialist • Identify where level 2 services are provided • Identify specialist MDTs	NSSG/ Medical Director / SCG	June 2008	As per 2.4 comments
12.	Agreed GP referral pathways for patients who require urgent referral to a skin cancer specialist (normally the dermatologist) in line with the NICE *Referral guidelines for suspected cancer*	• Processes for onward referral of cancer cases in line with the IOG to the local LSMDT, supported by agreed Network clinical protocols/guidelines • Agree referral arrangements between PCOs & diagnostic teams	NSSG Chair / LSMDT Leads	March 2008	
13.	Location of the designated hospitals within the Network where LSMDTs will be established.	• 2 or more designated clinicians to take responsibility within each LSMDT for providing rapid diagnostic and treatment service, ideally in the same clinical session. • Ensure patients are reviewed by the LSMDT. • Arrange rapid onward referral to the SSMDT. where appropriate	NSSG	March 2008	
14.	Agreed pattern of referring PCTs to each LSDMT and catchment populations of referring PCTs/practices for planning purposes.		Network Board / PCTs / SCG	September 2007	
15.	Confirmation that Network primary care referral guidelines for skin cancer have been distributed to GPs	• Agree primary care referral guidelines • Ensure distribution to GPs	NSSG / DND	Compliant	
16.	Guidelines	• Agree the specific guidelines between teams across the Network and if necessary between neighbouring Networks • Develop and agree Network clinical	NSSG Chair / L/SSMDT Leads	March 2008	

		protocols/guidelines			
17.	Agree location of SSMDT and catchment populations of referring PCTs/practices to the SSMDT for planning purposes.	• Identify host organisation for SSMDT	NSSG/ Medical Director / SCG	December 2009	As per 2.4 comments
18.	Surgeons within the SSMDT perform at least 15 block dissections each per year (groin or axilla). Each surgeon to undertake all dissections at a single named hospital.	• provide supporting data e.g. local audit data showing numbers of block dissections previously undertaken by each of the surgeons during the past year	SSMDT Leads / NSSG Audit Lead	December 2009	As per 2.5 comments
19.	SSMDT will play lead role in establishing the service for Moh's surgery, ensuring sufficient workload for each clinician.	• Confirm there is a register identifying the named clinicians to perform Moh's surgery within the Network. • Clinicians to have received training approved by the lead clinician of the Skin NSSG and where this is not the case the proposal should confirm this will take place.	SSMDT Leads	Dependent on Pan Birmingham IOG Action Plan	Network patients requiring Moh surgery are referred to Pan Birmingham Cancer Network
20.	Clinicians performing Moh's should undertake a min 50 procedures per year.			As above	PBCN issue
21.	Agree supra Network services for rare skin tumours	• Identify host organisation for the supra Network MDT • Identify core medical members of team, incl. specialist clinician (usually a dermatologist), specialist oncologist and dermato-pathologist. • SCG to confirm access to TSEB (Total Skin Electron Beam) radiotherapy is available and the hospital site where provided	SSMDT Leads / SCG Lead	Already taking place	Rare tumours pathways already in existence e.g. to PBCN or GM&CCN
22.	Agree specialist clinics for skin cancer transplant patients	• identify proposed site(s) of the specialist clinic(s) for skin cancer for	NSSG / SCG	March 2009 for new	This service is variable across the Network

		transplant patients		pathways	Need to develop a full service
23.	Access to clinical genetics services or specialised dermatology service for patients with a genetic predisposition to skin cancer	• Identify proposed site(s) of genetics services or specialised dermatology service	NSSG / SCG / DND	Already taking place	Genetic services provided from Pan Birmingham with some locally held clinics
24.	Agree the configuration of diagnostic	• Agree configuration of diagnostic/local care/ specialist teams for the Network •	SMDT Leads / Imaging Lead	September 2007	
25.	Agree the configuration of diagnostic	• Ensure Histopathology labs have accreditation or working towards • Ensure working towards double histopathology reporting	SMDT Leads / Pathology Lead/ NSSG Chair	September 2008	
26.	Easy access to immunophenotyping, molecular biological and cytogenic facilities		SMDT Leads / Pathology Lead/ NSSG Chair	September 2008	Access to service provided in Birmingham
27.	Sentinel Node Biopsy performed in centres with expertise in the context of clinical trials		NSSG Chair / Cancer Research Network Director	June 2009	This service is routinely undertaken for the Black Country at Russells Hall, Dudley. The NSSG is to develop a whole Network referral pathway to provide the service for the NW area
28.	Ensure ILP and ILI undertaken at supra regional centres		Trust Skin Lead Clinicians	Already in place	Patients requiring ILI are referred to Selly Oak Hospital, Birmingham Patients requiring IPL are referred to Glasgow
29.	Appropriate radiotherapy equipment, including orthovoltage radiotherapy machines		Network	Compliant	Radiotherapy available at all three Network Radiotherapy Centres
30.	Ensure high quality patient information	• Review patient information across Network to ensure high quality standard and uniformity of information	NSSG/ Network Nurse Director	On going during 2007/08 and 2008/09	

4.0 Assessing and managing risk associated with action plans

	Key Risks	Risk Management Plan
Activity	Actual activity may vary significantly from predicted	It is recommended that the activity is reassessed and re costed after 1 year's experience of service
	Service Redesign in the Region as a whole may impact on local Network planning given the size of the Network	Agree strategic developments with RSG and SHA in collaboration with PCTs
	Local service redesign or development of skin services may adversely affect other local delivery plans	Agree service developments with local managements and PCTs
	Reorganisation unacceptable to patients - travelling distances within GMCN considerable, supra Network MDT working could increase these and may lead to patients declining treatment	Involving patients in decision making Information for patients & primary health care teams Monitor patient satisfaction
Workforce	Failure to recruit	Accurate baseline data Accurate staffing profile to identify potential retirements Explore opportunities for skill mix and role redesign
	Retention of staff	Improving Working Lives Continuing Professional Development
	Staff training	Ensure appropriate training in place for identified staffing requirements
Governance	Audit and consistency across the Network must be ensured	Monitor and audit all change Monitor patient outcomes to present to the Network Board
	Reduction in quality of outcomes due to: • Lack of funding • No clinical buy in • Clinicians not using guidelines	Ensure appropriate business case(s) developed and submitted to Local Delivery Planning process for funding Ensure Network agreed guidelines and treatment portfolio available and used across Network
	Specialist MDT fails, due to: • Lack of attendance from all sites • Clinical conflict Availability of facilities for meetings	Provide facilitation to support development of MDT Ensure clinical guidelines are in place
	Supra-Network MDT lack of capacity/ expertise to take GMCN patients	Modify shared care arrangements as necessary
	Reconfiguring skin services will have an impact on other services, eg diagnostics, pathology, pharmacy	Ensure that all services likely to be affected are consulted and engaged

GREATER MIDLANDS CANCER NETWORK
Skin Network Site Specific Group

Cancer Action Team
Department of Palliative Medicine
St Thomas' Hospital
London SE1 7EH

Tel: 020 7188 0896
Fax: 020 7188 4727

07 January 2008

Tricia Lowe
Network Director
Greater Midlands Cancer Network
The Chestnuts,
New Cross Hospital
Wolverhampton
WV10 0QP

Dear Tricia

Re: Implementation Summary for Skin IOG

With reference to previous conversations, I am writing to let you know that the implementation summaries received in response to the skin IOG have now been analysed for their consistency with the NICE Guidance, together with the key milestones and timescales set out in earlier correspondence. It is recognised that each plan is the culmination of intensive planning, discussion and clinical commitment within networks. Please would you thank all who have been involved on our behalf.

With regard to your plans, we support the broad direction, but the summary raises a few questions that we would like a response to so that we can move to a position where we can finally sign off your summary.

The draft implementation summary sets out the intention to establish a 2nd Specialist Skin MDT at a location to be agreed. Has the Network been able to make any progress in its thinking about the establishment of this 2nd MDT, including where it will be hosted? There is a sufficiently large population to support 2 SSMDTs, but the IOG states that if 2 or more SSMDTs are established in one cancer network, there should be strong links between them. The IOG also states that there should be a separation of roles between SSMDTs where there are more than one in any Network e.g. patients with lymphoma and other rare skin cancers should be dealt with by only one SSMDT in the network. (Page 56). Again I should be grateful if you could let me know whether the Network has considered how it will ensure that the 2 SSMDTs will be compliant with this particular aspect of the IOG.

The draft implementation summary commented that access to Mohs surgery was dependent upon the Pan Birmingham Cancer Network's implementation summary, but indicated that patients from your Network will be referred to the service within Pan Birmingham. Are you now able to confirm that this will be the arrangement for this particular procedure?

At the time the draft summary was submitted it was stated that a prospective audit was being undertaken with Pan Birmingham Cancer Network with regard to the numbers of block dissections being undertaken by individual surgeons. Following this audit a decision would be made about referral pathways. I should be grateful if you could provide me with an update on the current position.

I should be grateful if you could provide me with an update on the Network's current thinking with regard to the development of a specialist clinic for transplant patients.

I should also be grateful if you could let me know what progress the Network has been able to make in developing plans for the provision of a community skin cancer service since the publication of the national guidance.

Finally, I acknowledge that there were still a number of unknown factors at the time that the draft summary was submitted, but I am sure that you are aware that there is an expectation that you will be developing, robust processes to undertake comprehensive baseline reviews of additional service requirements and to clarify the additional investments needed to ensure that your milestones are achieved and the guidance implemented.

I look forward to receiving your responses to the above issues, but if in the meantime there are any issues you wish to discuss further then please do not hesitate to contact me by e-mail or telephone (0207 188 0896).

Once again, please pass on our thanks to all who have been involved to date in the development of the implementation summary.

Yours sincerely

Stephen Parsons
National Cancer Action Team

GREATER MIDLANDS CANCER NETWORK
Skin Network Site Specific Group

10th March 2008

Stephen Parsons
National Cancer Action Team
Department of Palliative Medicine
St Thomas' Hospital
London SE1 7EH

Dear Stephen

Re: Implementation Summary for Skin IOG

Further to your letter of 7th January 2008.
Following the recent meeting of the Network Skin Network Site Specific Group meeting (NSSG), we are now able to make a response to the questions raised in your correspondence.

CAT Query:
The draft implementation summary sets out the intention to establish a 2nd Specialist Skin MDT at a location to be agreed. Has the Network been able to make any progress in its thinking about the establishment of this 2nd MDT, including where it will be hosted?
There is a sufficiently large population to support 2 SSMDTs, but the IOG states that if 2 or more SSMDTs are established in one Cancer Network, there should be strong links between them. The IOG also states that there should be a separation of roles between SSMDTs where there are more than one in any Network e.g. patients with lymphoma and other rare skin cancers should be dealt with by only one SSMDT in the Network (Page 56). Again I should be grateful if you could let me know whether the Network has considered how it will ensure that the 2 SSMDTs will be compliant with this particular aspect of the IOG.

GMCN response:
Please note that our draft implementation summary (Page 7) identified that there was an existing SSMDT in the adjacent Pan Birmingham Cancer Network, where some patients are referred at present.
It also stated that the issue of SSMDTs within the GMCN Network had not yet been resolved, but that the NSSG wished to develop 2 SSMDTS within the Network.
SSMDTs were discussed at the last meeting and work continues on the possibility of having a SSMDT in the north of the Network and another in the south. Stronger links between the proposed SSMDTs still need to be demonstrated before a final decision can be made.

With respect to lymphoma, no one Trust Skin Team within our Network is able to set up as specialist lymphoma team. We are happy to refer to a tertiary supra Network centre. This issue was discussed at the last NSSG and we agreed that nominated supra Network centres that we can refer to, are Selly Oak, Birmingham; The Christie and St John's, London.

CAT Query:
The draft implementation summary commented that access to Moh's surgery was dependent upon the Pan Birmingham Cancer Network's implementation summary, but indicated that patients from your Network will be referred to the service within Pan Birmingham. Are you now able to confirm that this will be the arrangement for this particular procedure?

GMCN Response:
At present the appropriate patients from our Network are referred to the Pan Birmingham Cancer Network for Moh's surgery. The NSSG has also agreed The Christie Hospital, Manchester as an alternative to give patient choice.

CAT Query:

At the time the draft summary was submitted it was stated that a prospective audit was being undertaken with Pan Birmingham Cancer Network with regard to the numbers of block dissections being undertaken by individual surgeons. Following this audit a decision would be made about referral pathways. I should be grateful if you could provide me with an update on the current position.

GMCN response:
The audit template has now been developed for this Network wide audit to take place. It has agreement from the plastic surgeons involved across the GMCN Network
The template is now to be shared with colleagues in the Pan Birmingham Network, through discussions between the two NSSG Chairs.
Following discussion with our Zonal Cancer Peer Review Quality Team, we are now awaiting the definitive skin measures, to see if the figure stated of 15 block dissections will change after the consultation period. Following receipt of the definitive measures, the content of the audit may need to be amended.

CAT Query:
I should be grateful if you could provide me with an update on the Network's current thinking with regard to the development of a specialist clinic for transplant patients.

GMCN response:
It is difficult for all the Trusts within the Network to provide separate clinics for transplant patients. We are all now identifying transplant patients within the dermatology outpatients' clinics to ensure that they receive at least an annual review. The University Hospital of North Staffordshire, who has a dedicated dermatology nurse for surveillance, and the Royal Wolverhampton Hospital both have separate clinics for this group of patients.

CAT Query:
I should also be grateful if you could let me know what progress the Network has been able to make in developing plans for the provision of a community skin cancer service since the publication of the national guidance.

GMCN response:
The provision of a community skin cancer service is still at an early stage of development within the Network. A Skin NSSG sub-group has been set up to take this development forward. The Skin NSSG sub-group is being led by a PCT commissioner and the first meeting of the group takes place on 14th March 2008.

I hope these responses provide you with the information that you require.

But please do not hesitate to contact myself or Joan Jackson, Deputy Network Director, should you require any further information.

Kind regards

Yours sincerely

Tricia Lowe
Director
Greater Midlands Cancer Network

Appendix 3 Measures: 08 1C 103j and 104j

DATA COLLECTION POLICY

The NSSG have agreed common priorities for data collection in line with national priorities e.g. cancer waiting times. The NSSG is responsible for agreeing the Network wide dataset

Measure 08-1C-103j Agreed Network Wide Minimum Dataset (MDS)
Measure 08-1C-104j Agreed Network Wide Policy specifying:

- Which type of team should collect which portion of the MDS.
- When each data item should be captured on the patient pathway;
- How the data will be stored and managed within all appropriate local data systems.

SKIN NSSG AGREED NETWORK-WIDE MINIMUM DATASET

The Skin NSSG has agreed a network-wide minimum dataset (MDS) to include the datasets mandated by the Dataset Change Notice (DCSN) 20/2008 and the Cancer Reform Strategy (December 2007).

Cancer Waiting Times

From the 1st January 2009 the NSSG MDS includes the updated cancer waiting times dataset as outlined in the DSCN 20/2008. The full dataset it outlined in DSCN 20/2008 published in September 2008 can be found on the Connecting for Health website (http://www.connectingforhealth.nhs.uk/dscn/dscn-2008/data-set-change-1/dscn20-2008.pdf).
Prior to the 1stJanuary 2009 all Trusts were collecting the dataset applicable to the previous cancer waiting times standards.

All Provider Trusts are collecting the Going Further on Cancer waiting Times dataset for routine submission and upload to the Cancer Waiting Times Database.

Cancer Registry

The Cancer Registry MDS is currently identified within the National Cancer Dataset v4.5 where any data item required for the cancer registry process is flagged with an asterix.
The local Cancer Registry, WMCIU (West Midlands Cancer Intelligence Unit) currently is responsible for collecting its own data; this is primarily from pathology reports and case notes. This process is undertaken manually and the Cancer Registry is able to extract all of the relevant data items.
The inclusion in the Cancer Reform Strategy included the requirement for Trusts to provide data in electronic format to registries. The Cancer Reform Strategy stated that the information that will be required to populate the cancer registry dataset will include:

- The Royal College of Pathologist minimum datasets
- Information on staging and co-morbidity
- National Radiotherapy dataset
- Information on chemotherapy

The requirements for electronic submission of the cancer registry dataset by Provider Trusts is included the NHS National Contract. This includes the requirement that Trusts will be submitting the full cancer registry dataset to the cancer registry by March 2011.

All Trusts within the GMCN are working in collaboration with WMCIU to develop agreed action plans with implementation timescales to commence the submission of the dataset electronically. Electronic data submission will commence during in 2009 for selected sections of the dataset as outlined in local Trust action plans.
Full submission in 2011 will include electronic submission of data from MDTs. The
Cancer Registry will be working alongside Trusts and the Network Information Staff to ensure a smooth transition between the manual and electronic systems.

Collection and Storage of the NSSG Minimum Dataset
The Skin NSSG endorses the GMCN policy for cancer data collection and storage:

- **All data items should be collected at the most appropriate point on the patient pathway**
- **Provider Trust to agree locally the most appropriate personnel and systems for the collection and storage of the agreed minimum dataset.**
- Collection of clinical data items will be supported by appropriate clinical input from core members of the MDT
- Provider Trusts are responsible for the collection, storage and upload of data items in the Going Further on Cancer Waiting Times dataset.
- Action plans to be developed between WMCIU and Acute Trust to determine the transition process between 2008 and 2011 for the collection and electronic submission of the cancer registry dataset.
- Data items should be stored appropriate an electronic format to allow upload into approved national systems and databases.
- Storage and transfer of patient identifiable information should adhere to all relevant National guidance and local Trust policies.

Appendix 4 Measures:08-1C-105j & 106j

NSSG AUDIT OF SKIN CANCERS TREATED IN GENERAL PRACTICE

INTRODUCTION

In 2006 the National Institute for Health and Clinical Excellence (NICE) published guidance on Improving Outcomes for People with Skin Tumours including Melanoma. The guidance included recommendations for the management of skin cancer by doctors working in the community as summarised below:
All GPs will be expected to recognise and make management decisions on patients with these conditions on a regular basis. This guidance recommends that while precancerous lesions can be safely managed by any GP who has undergone appropriate training (as outlined in the NICE *Referral guidelines for suspected cancer*), the planned treatment of low-risk BCCs should be restricted to approved doctors working in the community, usually a GPwSI, or the LSMDT/SSMDT. All other skin cancers should be referred to the LSMDT in the first instance.
In some areas, there may be suitably trained doctors who work in specialist hospital departments and who wish to see and treat patients with precancerous skin lesions and low-risk BCCs in the community. The need for community skin cancer clinics will vary according to the expertise available and ease of access to local hospital departments – they may well be more appropriate in rural areas than in urban areas. All doctors and specialist nurses working in the community who knowingly treat skin cancer patients should be approved by, and are accountable to, the local LSMDT/SSMDT skin cancer lead clinician. They should work closely together to agreed local clinical protocols for referral, treatment and follow-up. These should be coherent with Network-wide clinical protocols and signed off by the Network site-specific lead for skin cancer.
Depending on local circumstance, community skin cancer clinics could be based in GPs' surgeries, community hospitals or diagnostic and treatment centres where these exist. Patients could be referred to these clinics by local GPs or members of the LSMDT/SSMDT. For instance, when a diagnosis of low-risk BCC is made in a dermatology clinic, the patient may prefer the surgery to be carried out in the community if the specialist agrees this to be appropriate. Patients could be seen by these teams for treatment and follow-up when appropriate, according to agreed protocols and patient choice.
Any doctor or specialist nurse who wishes to treat patients with skin cancer should have specialist training in skin cancer work, be a member of the LSMDT and undergo ongoing education. In the absence of a national body to determine the surgical training within the remit of skin cancer, this should be determined by the network site-specific group for skin cancer and be consistent with the NICE *Referral guidelines for suspected cancer*.29 All doctors participating in the MDT should have a letter of appointment from the MDT lead clinician. Ideally all doctors treating patients with skin cancer should have attended a recognised skin surgical course. They should also work at least one session per week as a clinical assistant, hospital practitioner, associate specialist or staff-grade doctor in the local hospital department. This should be in a parallel clinic with an appropriate hospital specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT. This applies to GPwSIs as well, as specified in the joint recommendations by the DH, RCGP and BAD.30,31 This is considered essential to maintain skills and promote dialogue with the specialist.
A basic knowledge of skin cancer histopathology reporting and terminology is expected. Eligible doctors should either be GPwSIs employed by the PCT/LHB or non-career-grade doctors employed by the hospital trust. PCTs and LHBs should only accredit GPwSIs for skin cancer work if they comply completely with the DH, RCGP and BAD guidelines on GPwSI working.32,33 The recommendations include the need for the GPwSI to work at least one session per week in the special interest area. The majority of the practitioner's time should be spent as a GP, and this is usually considered to be at least three sessions per week.

Skin cancer CNSs should work alongside the doctors and carry out some forms of treatment such as cryotherapy, skin surgery and photodynamic therapy (PDT). They would also be involved in counselling, health promotion and follow-up of selected groups of patients where appropriately trained and would also ensure that the necessary liaison occurs between the hospital and community-based care. Any doctor, nurse or other practitioner who carries out surgical procedures on skin cancer patients should be appropriately trained and have his or her work audited and appraised.

The role of the doctor working in the community

The doctor working in the community should:

- Manage and follow up, when indicated, patients with low-risk

BCCs and precancerous lesions in the community (see Box 1 and Figure 14) by working to agreed protocols as defined by the lead clinician of the LSMDT/SSMDT.

- Provide a rapid referral service for patients who require specialist management through the LSMDT or SSMDT.
- Be responsible for the provision of information, advice and support for patients managed in primary care and their carers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.

The Greater Midlands Skin NSSG agreed an audit in order to assess the numbers of patients treated for skin cancer in General Practice and the number of General Practitioners currently treating skin cancer in the community.

METHOD

Each hospital/LSMDT within the NSSG collected data for their locality for the calendar year 2007.
The local hospital histopathology databases were searched to determine the following:

The total number of skin cancers treated in General Practice in 2007.

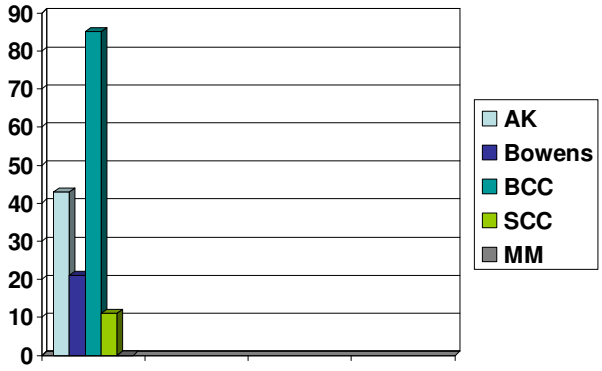
The histological type of those skin cancers treated.

The number of General Practices treating skin cancers and the number of cancers treated in each practice.

RESULTS

The results are summarised in the following tables:

Skin histologies from GPs RWH 2007

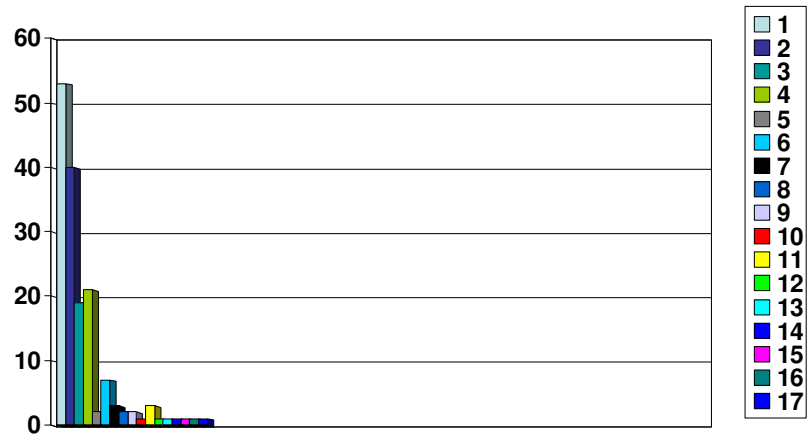


Skin cancer histology from GPs RWH 2007

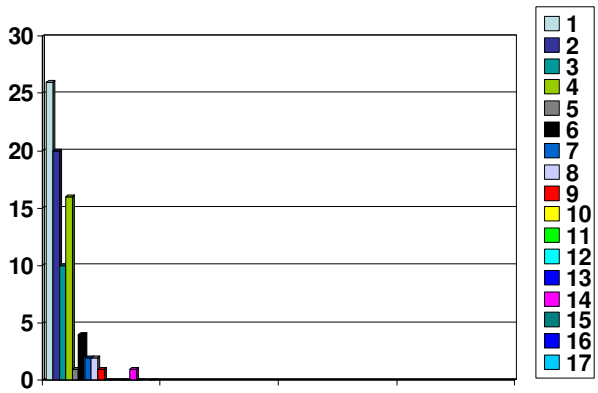
Total skin specimens from GP surgeries
1390

Malignant/premalignant 156
44 AK
20 Bowens
83 BCC
9 SCC

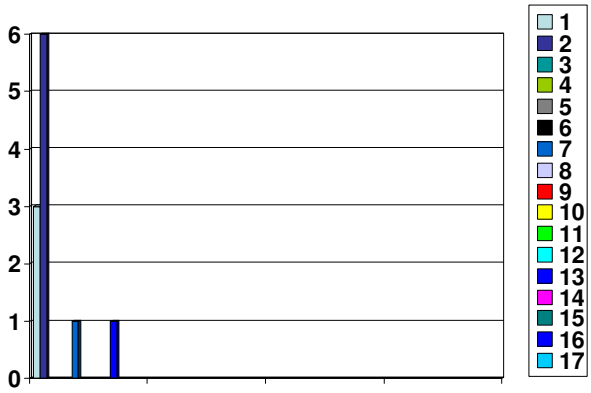
Malignant/ premalignant lesions by practice (RWH)



BCC's by practice (RWH)



SCC's by practice (RWH)



Skin cancer histologies from GPs UHNS

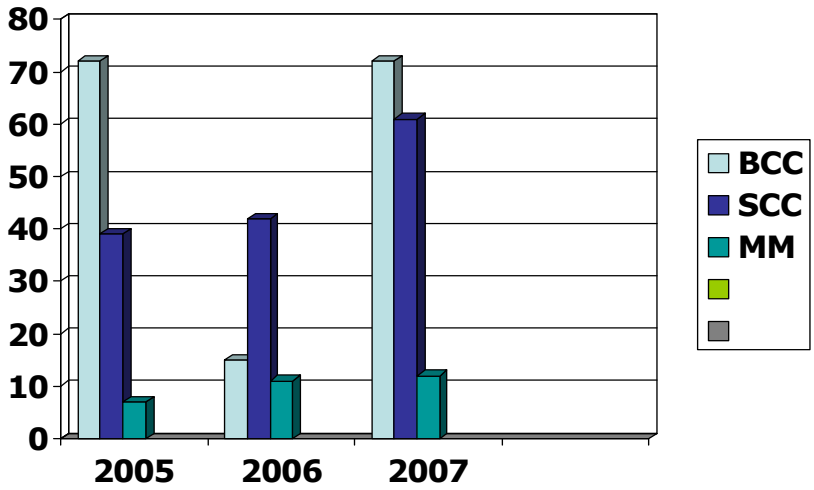
Estimates per annum

- Total skin specimens = 2000

- 2005 118 cancers (36 practices)
  72 BCC
  39 SCC
  7 MM

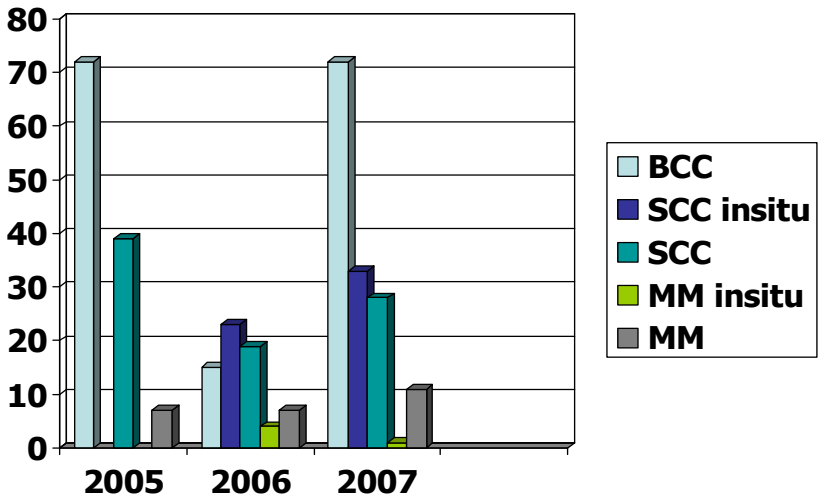
UHNS 3500-4000 biopsy specimens
886 BCC
344 SCC
110 MM

Skin histologies from GPs UHNS

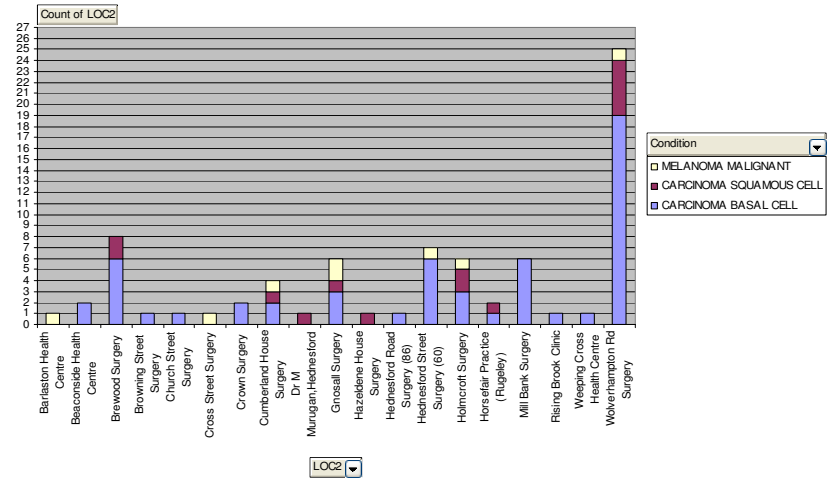


Skin histologies from GPs UHNS

Broken down into insitu and invasive lesions for 2006 and 2007 (SCC and MM)



Mid Staffs Hospital



SATH Audit to record numbers of confirmed skin cancer biopsies taken between 1st January 2007 and 31st December 2007.

Retrospective survey of histology reports recorded in Shrewsbury Histopathology Department.
Histologies sent out of the area unable to be recorded.

Advanced Primary Care Service (APCS) BCC reports.
Results; Total = 80

January = 11	(high risk = 3. low risk = 8)
February = 5	(high risk =4. low risk = 1)
March = 8	(high risk = 5. low risk = 2. unknown = 1)
April = 9	(high risk = 4. low risk = 5)
May = 10	(high risk = 5. low risk = 5)
June = 2	(high risk = 1. low risk = 1)
July = 3	(low risk = 3)
August = 4	(high risk = 3. low risk = 1)
September = 3	(high risk = 1. low risk = 2)
October = 5	(high risk = 3. low risk = 2)
November = 12	(high risk = 2. low risk = 10)
December = 8	(high risk = 2. low risk = 6)

GP BCC biopsy reports 1/1/07 – 31 /12 /07
Results; Total = 219
High risk = 5.
Low risk = 46
Unknown = 1

SATH Audit to record numbers of confirmed skin cancer biopsies taken between 1st January 2007 and 31st December 2007 contd.

SCC Total = 38

APSC = 3	PP = 6	GP's = 29
Exc = 3	Exc = 5	Exc = 17
Punch = 0	Punch = 1	Punch = 5
Curette = 0	Curette = 0	Curette = 7

Bowens (in-situ SCC) Total = 76

APCS = 19	PP = 5	GP's = 52
Exc = 5	Exc = 4	Exc = 15
Punch = 10	Punch = 1	Punch = 14
Curette = 4	Curette = 0	Curette = 23

GP -MM biopsies Jan – Dec 2007

MM Total = 6
Excision = 6
Fully excised = 2
Further treatment/referral = 4
Referred another hospital = 2

Mm In-situ Total = 5
Excision = 4
Fully excised = 3
Further treatment/referral = 3
Referred another hospital = 2

Other tumours Total = 2 (Merkel cell = 1, Atypical fibro-xanthoma = 1)
Excision = 2
Fully excised = 1
Referred another hospital = 2

Dudley Group of Hospitals

As regards community biopsied BCC, Dudley can report the following:

- A total of **59** BCC were biopsied in the community (either excision or incision biopsies) during calendar year 07-08
- These were from a total of 30 surgeries
- The range of biopsies per surgery was 1-10, the mode was 1
- Therefore in Dudley it seems that only one-two surgeries may be setting out to intentionally treat BCC (the second highest biopsy rate was 5)

DISCUSSION

The data indicates that a significant number of patients with skin cancer are currently diagnosed and treated in General Practice. Most of these are patients with Basal Cell Carcinoma but some patients with Squamous Cell Carcinoma and Malignant Melanoma were also identified.
General Practitioners in Shropshire treated the greatest number of patients with skin cancer (299 BCC, 38 SCC, 76 SCC in situ, 6 MM) although a significant proportion of the BCCs treated were seen by the Advanced Primary Care Service. General Practitioners from Stoke and surrounding areas treated proportionately less cases (72 BCC) but did treat/biopsy significant numbers of patients with Squamous Cell Carcinoma (33) and Malignant Melanoma (10). Mid-Staffordshire General Practitioners treated fewer BCCs (55) but again significant numbers of SCCs (14) and MMs (8). General Practitioners from Wolverhampton treated mainly BCCs (83) and SCCs (9). Data from Dudley suggests that only small numbers of patients with skin cancer are treated in General Practice (59 BCCs).
The breakdown of cases between different General Practices was examined for South Staffordshire and Wolverhampton. This showed one practice in the South Staffordshire area was treating proportionately more cases than others. RWH data shows four practices which treated the majority of cases (2 of these are within South Staffs PCT).

CONCLUSIONS

The audit shows that a significant number of patients with skin cancer are currently treated in General Practice.
In order to comply with IOG guidance patients with Malignant Melanoma, Squamous Cell Carcinoma and High Risk Basal Cell Carcinoma should not be managed in General Practice but should be managed by the Local Skin MDT and of appropriate the Specialist Skin MDT.
Low Risk Basal Cell Carcinoma could be managed in a Community setting but only by Practitioners who fulfil the IOG recommendations regarding training and links with the Local Skin MDT.
The number of skin cancer cases seen in General Practice varies across the NSSG. If responsibility for the management of all or most of these patients were to be transferred to the local Hospital services there would be an increase in workload for those services.

ACTION

Agreement on setting up of NSSG GP training subgroup, in conjunction with representatives of the local PCTs, to determine the way forward for Community Skin Cancer Services across the Greater Midlands Cancer Network.

Dr Simone Oliwiecki
Consultant Dermatologist / MDT Lead, RWH

NSSG AUDIT OF BLOCK DISSECTIONS FOR SKIN CANCER
Jan 04-Dec08

INTRODUCTION

Lymph node status is very important prognostic factor at presentation, with 10 year survival reduced by 20-50%. The Breslow thickness is best indicator of the likelihood of metastasis. In a recent follow up study of new diagnosis of melanoma (Garbe et al Cancer 2007 109. 1174-82) found that 7% of cases presented with stage III disease and 4% with stage IV disease.

METHOD

This was a retrospective audit and each hospital / LSMDT within the NSSG was asked to forward data for period Jan04-Dec08. information requested was based on audit form used at DGOH. Data was received from Dudley Group (DGOH), Stoke (UHNS), Midstaffordshire (Midstaff) and Royal Wolverhampton Hospital (RWH). Shropshire and Telford (SaTH) reported that all of their blocks , which numbered less than 5 a year, were referred to Birmingham (UHB)

RESULTS

The results are summarised in the following tables:

	DGOH	UHNS	MIDSTAFF	RWH	GMCN
Axilla	22	20	2	4	48 (57%)
Groins	16	16	3	1	36 (43%)
Total	38	36	5	5	84

Data for a total of 84 block dissections carried out in Dudley Group (DGOH), Stoke (UHNS), Mid Staffordshire (Mid Staffs) and Royal Wolverhampton Hospitals (RWH) was received. The majority were from DGOH and UHNS. Overall there were more axillary dissections than groin dissections and overall percentages are given under GMCN.

AGE AT SURGERY

	DGOH	UHNS	MID STAFF	RWH
Years	58 (31-87)	63.5 (21-102)	56 (41-70)	64 (52-76)

PATHOLOGY OF BLOCKS

	DGOH	UHNS	MID STAFF	RWH
MM	37	30	5	5
SCC	1	6	0	0

The majority of blocks were for melanoma

BRESLOW THICKNESS

	<1mm	1-2mm	2-3mm	3-4mm	>4mm	NR	Mean
DGOH	2	8	12	6	6	4	-
UHNS	3	5	6	3	9	3	4.47
MID STAFF		1	1	1	1	1	6.6
RWH		1			3	1	8.6

Mean Breslow thickness for DGOH was not available and was 4,47mm for UHNS. The mean for Midstaffs and RWH was higher but in each case was distorted by one melanoma >15mm.

DURATION OF IN PATIENT STAY

	DGOH	UHNS	MIDSTAFF	RWH	GMCN
Axilla	7	10	3.5	5	6.4
Groins	8	12.6	2.6	4	6.8

Mean in patient stay was just over 6 days

COMPLICATION RATE

	DGOH	UHNS	MIDSTAF	RWH	GMCN
%	37	42	0	20	25

Complication rate varied from 0-42%, with overall mean of 25%. Midstaff did not report any early complications, and the rate was highest for UHNS.

ANALYSIS OF COMPLICATIONS

DGOH

	Nil	Seroma	Infection	Necrosis/ breakdown
Axilla	15 (68)	6 (27)	2 (9)	2 (9)
Groin	9 (56)	7 (43)	0	2 (12)

Seroma, Infection and wound breakdown were main immediate complications.

UHNS

	Nil	seroma	Infection	Necrosis / breakdown
Axilla	12 (60)	4 (20)	3 (15)	6 (30)
Groin	9 (56)	4 (25)	1 (6)	5 (31)

INDICATION FOR BLOCK – DGOH

SLNB	28
Metastasis (FNAC)	10

DGOH had >70% of cases following positive Sentinel lymph Node biopsy

DISCUSSION

All data collection was retrospective. The majority of Data was from DGOH and UHNS and hence the inclusion of data from the low volume units (Midstaff, RWH) may have distorted the picture. 84 cases over 5 years, amounts to about 16 cases per year carried out within the whole GMC network According to NICE guidelines document 'inproving outcomes for people with skin cancers including melanoma',

''At least two surgeons should have a designated interest in skin cancer surgery and perform at least 15 block dissections each (groin or axilla) per year".

The 15 number is going to be difficult to achieve within the network unless numbers are increased by retaining ALL blocks within the network and increasing indications for block dissections. Analysing our data, a smaller higher T-Stage correlates with higher likelihood of metastasis and this audit bears this out with mean breslow >4mm.

Inpatient stay at mean of 6 days is slightly higher than published studies. UHNS has highest length of inpatient stay. This is probably related to timing of drain removal (drainage <30mls hour) which may be a different to other units.

Complication rates are overall comparable to other units. UHNS blocks were all for macroscopic disease, compared to >70% of the DGOH blocks for microscopic disease following SLNB, which may explain the higher rate. Information regarding whether groin dissections were inguinal or ilio-inguinal was incomplete. Groin dissections are associated with higher complication rate, however our data seems to suggest that axillae have higher rate.

CONCLUSION

The minimum requirement of '15 per surgeon' is going to be an issue. Overall complication rates and in-patient stay are comparable with recent published studies. The 2 SSMDTS will need to review practice regarding infection rates and duration of inpatient stay and a further prospective audit in 3-5 years would close the audit loop.

Location of block dissection surgery

Name of SSMDT surgeon	**Minimum 15 block dissections per year (groin or axilla).**	**Location of hospital where block dissections are undertaken**
Mr Rayatt	Axillary Groin	UHNS NHS Trust
Mr Jaffe	Axillary Groin	UHNS NHS Trust
Mr Moimen	Axillary Groin	University Hospital Birmingham NHS Foundation Trust
Mr Mohan	Axillary Groin	Dudley Group NHS Trust

ACTION

Agree on prospective data collection and repeat audit to close audit loop.

Mr Sukh Rayatt Consultant Plastic Surgeon / MDT Lead, UHNS 25.11.09.

Appendix 5 Measures:08-1C-107j & 108j

Greater Midlands Cancer Research Network

Response to MDT report (Revised 210110)

MDT: Skin

Sites: RWHT, DGOH, MSFT, UHNS, SaTH

Comments by Professor David Ferry, GMCRN Clinical lead:

This NSSG has had few opportunities for research as The National Institute for Cancer Research portfolio for skin cancer is very limited , with only four interventional clinical trials open to recruitment.
The AVAST M study: Adjuvant Avastin Trial in high risk Melanoma - A randomised trial evaluating the VEGF inhibitor, bevacizumab (Avastin®),as adjuvant therapy following resection of AJCC stage IIB (T3bN0M0 & T4aN0M0), IIC (T4bN0M0) and III (TxN1-3M0) cutaneous melanoma, has been pending at UHNS and RWHT for a significant period due to delays at the coordinating centre for the study.
During this time some patients have been referred outside of the Network to participate in this trial.

Name Professor David Ferry

Signature: .....

Date; 9/12/09

Greater Midlands Cancer Research Network

MDT Response to Agreed Trials List

NSSG: **Skin**

MDT: **RHH** / Rwsh Wolverhampton

Hospital Sites Covered by MDT:

Date of Meeting:

Named MDT Research Lead: **Dr Grumett**

List of Agreed Trials

Trial Acronym	National Status	Local Status (Open/In set-up/Not to be opened/Stalled)	Reason Code for Not Opening (please see list of reasons)	Comments
Melanoma Cohort Study	OPEN	Open		
Pathological collaboration with translational Oncology Research Centre	OPEN	Open		
AVAST – M (NCRN)	PENDING	Pending		

Reasons for Not Opening Trial

01 - No clinician interest
02 - Trial to be closed soon
03 - Conflicts with another study
04 - Not Suitable for Trust/Site - Lack of Suitable Patients
05 - Not Suitable for Trust/Site - Specialist Centre/Equipment Required
06 - Funding Issues (please specify)
07 - Lack of Resources - Staff Capacity
08 - Lack of Resources - Support Services Capacity
09 - Lack of Resources - Other (please specify)
10 - Other Reasons (please specify)

Status	Type	Open to additional sites	
AVAST-M - Adjuvant aVAStin Trial in high risk Melanoma - A randomised trial evaluating the VEGF inhibitor bevacizumab (Avastin), as adjuvant therapy following resection of AJCC stage IIB (T4aN0M0) IIC (T4bN0M0) and III (TxN1-sM0) cutaneous melanoma.	Open	Interventional	Yes, within and outside lead country
Melanoma Cohort Study - The Melanoma Follow-Up and Case-Control Family Study	Open	Observational	Yes, within and outside lead country
The Melanoma Lifestyle Study - The Melanoma Lifestyle Study	Open	Observational	Yes, within and outside lead country

Accrual 2007/2008

MDT comments on trial accrual (current and previous)

Great difficulty in opening trials (especially AVASTM) difficulties at the co-ordinating centre have lead to delays of over 12 months in opening up!

Actions to be undertaken by MDT and time scales

Patients will be available to recruit into trials when they are actually open.

Additional information that you would like the MDT or Research Network to know

Review Date: .....

MDT Discussion of Agreed Trials List:

MDT Research Lead

Name (please print name): Dr Grumett

Signature: .....SG.....

Date: .....20/11/09.....

MDT Lead Clinician

Name (please print name):

Signature: .....

Date: .....

NSSG Discussion:

NSSG Chair

Name (please print name): Dr VIVEK MUDALIAR

Signature: .....

Date: 25/11/09

Authorised by:

GMCRN Clinical Lead

Name (please print name): Professor David Ferry

Signature: .....

Date: 1/12/09

Greater Midlands Cancer Research Network

MDT Response to Agreed Trials List

NSSG: SKIN

MDT: DERMPATH

Hospital Sites Covered by MDT: Stafford & Cannock Hospitals

Date of Meeting: 15th May 2009

Named MDT Research Lead: Dr E.M. LOCHEE-BAYNE

List of Agreed Trials

Trial Acronym	National Status	Local Status (Open/In set-up/Not to be opened/Stalled)	Reason Code for Not Opening (please see list of reasons)	Comments
Melanoma Cohort Study	OPEN	Not to be opened	04	
Pathological collaboration with translational Oncology Research Centre	OPEN	In Set-up		
AVAST – M (NCRN)	PENDING	Not to be opened	10	The MDT considered this to be a valuable study in which they would like to participate. It was decided it was appropriate an oncologist should act as PI. Unfortunately our visiting Oncologist from UHNS is not on Stafford site frequently enough to comply with the trial patient follow-up visits. UHNS are considering opening this trial and we have approached their MDT suggesting Stafford patients expressing an interest in the trial could be referred to their site.

Reasons for Not Opening Trial

01 - No clinician interest
02 - Trial to be closed soon
03 - Conflicts with another study
04 - Not Suitable for Trust/Site - Lack of Suitable Patients
05 - Not Suitable for Trust/Site - Specialist Centre/Equipment Required
06 - Funding Issues (please specify)
07 - Lack of Resources - Staff Capacity
08 - Lack of Resources - Support Services Capacity
09 - Lack of Resources - Other (please specify)
10 - Other Reasons (please specify)

Status	Type	Open to additional sites	
AVAST-M - Adjuvant aVAStin Trial in high risk Melanoma - A randomised trial evaluating the VEGF inhibitor bevacizumab (Avastin), as adjuvant therapy following resection of AJCC stage IIB (T4aN0M0) IIC (T4bN0M0) and III (TxN1-sM0) cutaneous melanoma.	Open	Interventional	Yes, within and outside lead country
Melanoma Cohort Study - The Melanoma Follow-Up and Case-Control Family Study	Open	Observational	Yes, within and outside lead country
The Melanoma Lifestyle Study - The Melanoma Lifestyle Study	Open	Observational	Yes, within and outside lead country

Accrual 2007/2008

MDT comments on trial accrual (current and previous)

Actions to be undertaken by MDT and time scales

Additional information that you would like the MDT or Research Network to know

Review Date: .....

MDT Discussion of Agreed Trials List:

MDT Research Lead

Name (please print name): E.M. LOCHER-BAYNE

Signature: .....

Date: 15.5.09

MDT Lead Clinician

Name (please print name): E.M. LOCHER-BAYNE

Signature: .....

Date: 15.5.09

NSSG Discussion:

NSSG Chair

Name (please print name): Dr VIVEK MUDAKAR

Signature: .....

Date: 25/11/09

Authorised by:

GMCRN Clinical Lead

Name (please print name): Professor David Ferry

Signature: .....

Date: 9/12/09

Greater Midlands Cancer Research Network

MDT Response to Agreed Trials List

NSSG: Skin

MDT: University Hospital of North Staffordshire NHS Trust

Hospital Sites Covered by MDT: Mid Staffs, Mid Cheshire, UHNS

Date of Meeting: 27th November 2008

Named Research Lead: Dr AM Brunt

List of Agreed Trials

Trial Acronym	National Status	Local Status (Open/In set-up/Not to be opened/Stalled)	Reason Code for Not Opening (please see list of reasons)	Comments
Melanoma Cohort Study	OPEN	Not to be opened	01	Not a RCT
Melanoma Lifestyle Study	OPEN	Not to be opened	01	Not a RCT
AVAST – M (NCRN)	OPEN	In set up, soon to be open	N/A	Lack of cooperation from trials centre
CAO 33 (NCRN)	Pending	Pending		1st line metastatic melanoma chemo trial

Reasons for Not Opening Trial

01 - No clinician interest
02 - Trial to be closed soon
03 - Conflicts with another study
04 - Not Suitable for Trust/Site - Lack of Suitable Patients
05 - Not Suitable for Trust/Site - Specialist Centre/Equipment Required
06 - Funding Issues (please specify)
07 - Lack of Resources - Staff Capacity
08 - Lack of Resources - Support Services Capacity
09 - Lack of Resources - Other (please specify)
10 - Other Reasons (please specify)

Status	Type	Open to additional sites	
AVAST-M - Adjuvant aVAStin Trial in high risk Melanoma - A randomised trial evaluating the VEGF inhibitor bevacizumab (Avastin), as adjuvant therapy following resection of AJCC stage IIB (T4aN0M0) IIC (T4bN0M0) and III (TxN1-sM0) cutaneous melanoma.	Open	Interventional	Yes, within and outside lead country
Melanoma Cohort Study - The Melanoma Follow-Up and Case-Control Family Study	Open	Observational	Yes, within and outside lead country
The Melanoma Lifestyle Study - The Melanoma Lifestyle Study	Open	Observational	Yes, within and outside lead country

Accrual 2007/2008

0, no RCTs open in 2007/8

MDT comments on trial accrual (current and previous)

AVAST-M - we are in the process of joining this study, awaiting Addenbrooke's trial centre.
CAO33 (NCRN adopted) – pending. Expected to open in Autumn 2009. Dr Brunt is UK Chief investigator.

Actions to be undertaken by MDT and time scales

- Review participation when NCRN or commercial trials are available
- Submit studies to Trust Cancer Clinical Trials Unit when they are identified, even if it is prior to opening.

Additional information that you would like the MDT or Research Network to know

Review Date: .....November 2009.....

MDT Discussion of Agreed Trials List:

MDT Research Lead

Name (please print name): Dr AM Brunt

Signature: .....

Date: .....

MDT Lead Clinician
Name (please print name): Dr B Tan

Signature: .....

Date: .....

NSSG Discussion:

NSSG Chair

Name (please print name): Dr VIVEK MUDAGIAR

Signature: .....

Date: 25/11/09

Authorised by:

GMCRN Clinical Lead

Name (please print name): Professor David Ferry

Signature: .....

Date: 9/12/09

Greater Midlands Cancer Research Network

MDT Response to Agreed Trials List

NSSG: Skin

MDT: Shrewsbury & Telford NHS Trust

Hospital Sites Covered by MDT: Royal Shrewsbury, Princess Royal-Telford, Bridgnorth.

Date of Meeting: 5th November 2009

Named MDT Research Lead: CNS Jane Davenport

List of Agreed Trials

Trial Acronym	National Status	Local Status (Open/In set-up/Not to be opened/Stalled)	Reason Code for Not Opening (please see list of reasons)	Comments
Melanoma Cohort Study	OPEN			
Pathological collaboration with translational Oncology Research Centre	OPEN			
AVAST – M (NCRN)	PENDING			

Reasons for Not Opening Trial

01 - No clinician interest
02 - Trial to be closed soon
03 - Conflicts with another study
04 - Not Suitable for Trust/Site - Lack of Suitable Patients
05 - Not Suitable for Trust/Site - Specialist Centre/Equipment Required
06 - Funding Issues (please specify)
07 - Lack of Resources - Staff Capacity
08 - Lack of Resources - Support Services Capacity
09 - Lack of Resources - Other (please specify)
10 - Other Reasons (please specify)

Status	Type	Open to additional sites	
AVAST-M - Adjuvant aVAStin Trial in high risk Melanoma - A randomised trial evaluating the VEGF inhibitor bevacizumab (Avastin), as adjuvant therapy following resection of AJCC stage IIB (T4aN0M0) IIC (T4bN0M0) and III (TxN1-sM0) cutaneous melanoma.	Open	Interventional	Yes, within and outside lead country
Melanoma Cohort Study - The Melanoma Follow-Up and Case-Control Family Study	Open	Observational	Yes, within and outside lead country
The Melanoma Lifestyle Study - The Melanoma Lifestyle Study	Open	Observational	Yes, within and outside lead country

Accrual 2007/2008
Nil

MDT comments on trial accrual (current and previous)

No patients currently undergoing trials.

Actions to be undertaken by MDT and time scales

MDT members to be updated on current trials at operational policy meeting 5th November 2009

Additional information that you would like the MDT or Research Network to know

Review Date: 5th November 2010

MDT Discussion of Agreed Trials List:

MDT Research Lead

Name (please print name): CNS Jane Davenport
Signature: .....
Date: 5th November 2009

MDT Lead Clinician

Name (please print name): Dr Susan Kelly
Signature: .....
Date: 5th November 2009

NSSG Discussion:

NSSG Chair

Name (please print name): Dr Vivek Mudaliar
Signature: .....
Date: 5th November 2009

Authorised by:

GMCRN Clinical Lead

Name (please print name): Professor David Ferry
Signature: .....
Date: 9/12/09

Apendix 6
Measures: 08-1A-209j, 210j, 211j, 212j,213j, 214j, 215j, 216j and 217j
Measures: 08-1C-110j, 111j, 112j and 113j

GREATER MIDLANDS SKIN CANCER NSSG

CLINICAL, PATHOLOGY, IMAGING, ANATOMICAL AND REFERRAL GUIDELINES 2009

CONTENTS

Measure 08-1C-110j

Skin Cancer NSSG Clinical Guidelines for management of skin cancer

The Greater Midlands skin cancer NSSG have agreed to adopt the UK and British Association of Dermatologists Guidelines as the Network Clinical Guidelines for Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma and Lymphoma.
These guidelines have been adapted with the kind permission of Lancashire & South Cumbria Cancer Services Network.

Internet links to these documents can be found below:

http://www.bad.org.uk/site/622/default.aspx

- Guidelines for the management of basal cell carcinoma (2008)
- UK Guidelines for the management cutaneous melanoma (2002)
- Multi-professional Guidelines for the management of primary cutaneous squamous cell carcinoma (2002)
- Joint British Association of Dermatologists and UK Cutaneous Lymphoma Group guidelines for the management of primary cutaneous T-cell lymphomas (2003)

The NSSG will review the above guidelines at least annually or as and when new Guidance is published.

Measure 08-1C-112j

Skin Cancer NSSG Pathology Guidelines

The Skin NSSG has broadly adopted the Royal College of Pathologists Guidelines for histological reporting of Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma and Lymphoma.
Dr Vivek Mudaliar, Consultant Histopathologist at The Shrewsbury & Telford Hospitals NHS Trust (SaTH) is the Lead Skin Pathologist in the Network. Dr Mudaliar is also a core member of the SaTH Skin LSMDT.
Dr. Mudaliar has written a more extensive set of guidelines, which has been agreed by all the lead skin cancer pathologists in the GMCN Network.
The Skin NSSG has adopted the Royal College of Pathology Guidelines for histological reporting of Basal Cell Carcinoma, Squamous Cell Carcinoma, Malignant Melanoma and Lymphoma.

Internet links to these documents can be found below:

http://www.rcpath.org/resources/pdf/skincancers2802.pdf
Basal Cell Carcinoma – page 5
Squamous Cell Carcinoma – page 11
Malignant Melanoma – page 17

Lymphoma. Internet links to these documents can be found below:
http://www.rcpath.org/resources/pdf/lymphomaminimumdatasetCORRECTED.pdf
The NSSG will review the above guidelines at least annually or as and when new Guidance is published.

Skin Cancer NSSG Pathology Guidelines

The following publications were consulted in preparation of these guidelines:

1 – Minimum dataset for histopathology reporting of skin cancers, issued by the Royal College of Pathologists, February 2002 (to be updated 2009). This publication is available at http://www.rcpath.org/index.asp?PageID=1165

2 – Improving outcomes for people with skin tumours including melanoma: The Manual February 2006 (http://www.nice.org.uk/guidance/index.jsp?action=download&o=28906)

3 – National Cancer Peer Review Programme Manual for Skin Cancer Services 2008: Skin Measures

General comments
The assessment of the surgical specimen by the pathologist has three main aims:

Diagnosis
Determination of prognostic factors
Determination of the adequacy of treatment

This assessment is essential to direct future treatment. It also identifies individuals who are eligible for inclusion in clinical trials.
Review of selected cases at a skin cancer multidisciplinary team meeting is important for confirmation and refinement of the original diagnosis, helps to improve communication between pathologists and those involved in direct clinical care, and acts as a form of audit.

Specimen types
Diagnostic (curettings, diagnostic punch biopsies, incisional biopsies, shaves)
Curative (excision biopsies, excisional punch biopsies)

Specimen examination
The guidance given in the minimum dataset issued by the Royal College of Pathologists should be followed (http://www.rcpath.org/index.asp?PageID=1165)

Microscopic assessment
Basal cell carcinoma – according to RCPath dataset
Squamous cell carcinoma – according to RCPath dataset
Melanoma – according to the RCPath dataset
Sarcoma – report to be based on WHO/FNCLCC classifications and standard texts
Lymphoma – to be reported based on WHOEORTC classification and standard texts

To supplement the experience of the reporting pathologist, reporting will be assisted by reference to standard textbooks and journal articles. The use of ancillary laboratory techniques may be required. Second opinions may be sought within the department or by referral for specialist review.

Ancillary laboratory techniques
All laboratories providing a pathology service should have at least conditional CPA accreditation and participate in an appropriate laboratory EQA scheme.

Many histochemical and immunohistochemical markers are available for use in the reporting of skin cancers, and include:

S100, Melan A, HMB45 in melanomas
Cytokeratins, EMA, BerEP4, in carcinomas
CD56, PGP9.5, NSE, Chromogranin, and other neuroendocrine markers for suspected Merkel cell carcinoma
S100, CD34, SMA, Desmin, CD31, and EMA for sarcomas
Markers commonly used for lymphomas include B and T cell markers, EMA, CD30, CD4, CD8, CD56, CD5, CD10, cyclinD1, CD23, BCL2, BCL6, and Alk1, amongst others.

Also available are cytokeratins 7 and 20, TTF-1, PSA, and oestrogen receptor for metastases of unknown primary.

The above list is incomplete, but panels may be determined according to standard texts and journal articles, based on the initial assessment performed on routine stains.

Commonly used texts
Skin cancer (general) - WHO Classification of Tumours, Skin Tumours, IARC
Skin cancer (general) - Pathology of the Skin with Clinical Correlations, 3rd Edition, Phillip H. McKee
Skin cancer (sarcomas) - Enzinger and Weiss's Soft Tissue Tumours, 4th Edition.
Skin cancer (lymphoid) - WHO Classification, Tumours of Haematopoietic and Lymphoid Tissues, IARC
Skin cancer (general) - Diagnostic Histopathology of Tumours, CDM Fletcher, 3rd Edition

Other texts may be used according to departmental preferences, and needs arising from individual cases.

CPD/EQA/local audit
All pathologists reporting skin malignancies must take part in an EQA scheme which includes skin malignancies. Schemes which may be relevant include general and specialist dermatopathology EQA.
They should also participate in CPD relevant to skin cancers.
There should also be regular local audit to examine the quality, consistency, and timeliness of local specimen handling and reporting of skin cancers.

Departmental workloads
The adequacy of staffing is examined by CPA assessments; staffing should be deemed to be adequate, or adequate on conditions imposed.

Local skin multidisciplinary team meetings
The following cases should be reviewed by the local skin cancer multi-disciplinary team, which has a histopathologist as a core member:
1 – High risk/recurrent/margin-positive basal cell carcinomas
2 – All squamous cell carcinomas
3 – All melanomas
4 – All cutaneous lymphomas
5 – All cutaneous sarcomas
6 – Rare skin tumours

There should be a nominated lead and deputy pathologist for the LSMDT. The lead histopathologist should attend over 50% of MDT meetings. Other histopathologists should be able to demonstrate some MDT attendance.

Specialist skin multidisciplinary team meetings
Two SSMDTs are present within the network. Cases referred to either SSMDT by another MDT should be reviewed by one or more histopathologist core members of that SSMDT.

Referral for review/specialist opinion
NICE recommends that diagnostic biopsies are reviewed in the centre where any definitive surgery is to be carried out.

For cutaneous sarcomas, these centres are currently outside the Greater Midlands Cancer Network.

For cutaneous lymphomas, according to IOG measure 08-1C-112j, there should be a named individual within the network, to whom all new cases of presumed lymphoma should be sent for a second opinion. There is no such individual at present, but as well as the two SSMDTs, a review pathway for lymphoma pathology is being negotiated within the network. It is anticipated that this will fulfil that role.

Tertiary referrals:
The centre or individual to whom difficult cases are referred will depend on the presence of pre-existing established connections (including SLAs with individual Trusts). A list of some of the experts used is given below.

Dr. E. Calonje, St. John's Institute of Dermatology, London
Dr. A. Robson, St. John's Institute of Dermatology, London
Dr. R. Carr, Warwick Hospital, Warwick.
Professor M. Cook, Royal Surrey
Professor David Slater, Sheffield.

These guidelines were created using the Three Counties Cancer Network pathology guidelines as a template. Permission for this was received from the author of that report, Dr. Paul Craig.

Revised November 2009
Dr. Vivek Mudaliar

Consultant Pathologist Representative/ NSSG Chair
Skin NSSG
Greater Midlands Cancer Network

Measure 08-1C-111j

NSSG Imaging Guidleines for patients with Malignant Melanoma

Stages 1A, 1B, 2A. Imaging is not usually indicated in asymptomatic patients with early stage disease. Imaging for evaluation of specific symptoms or signs.

Stage 2B. Imaging only if directed by clinical presentation.

Stage 3 (clinical node positive). Staging CT scan of thorax, abdomen and pelvis (plus post contrast CT brain, or MR brain, if any neurological symptoms). Other imaging – e.g. patients with a primary site in the head and neck region will usually have an MRI scan of the head and neck.

NB. Patients with regional nodal disease, but no other metastases demonstrated on the staging CT scans, may need to have a PET-CT scan, after MDT discussion, if radical treatment is planned. (Local regional PET-CT guidelines 2009).

Stage 4 Metastatic disease. Full staging CT scans of thorax, abdomen, pelvis and brain.

All stages: Other investigations, including ultrasound, MRI or PET-CT scans may be appropriate in certain cases. A plain CXR may be required preoperatively for patients undergoing surgery.

Follow up: Re-Staging CT scans may be appropriate for assessment of response to treatment. (The CT brain scan does not necessarily need to be repeated if negative at initial staging). Imaging can be directed to specific symptoms and signs, as clinically indicated.

Nicola Lane
Imaging Representative
Skin NSSG

23.11.2009

Review: November 2010

Measure 08-1A-211j

GMCN Skin NSSG Arrangements for Immunocompromised patients with skin cancer

Within our Network there are no Acute Trusts which perform transplants

University Hospital of North Staffordshire (UHNS) has dedicated clinics for renal patients; which is accessed by Mid Staffordshire NHS Foundation Trust (MSFT).
HIV patients are cared for by their GUM consultant and referred appropriately for KS.

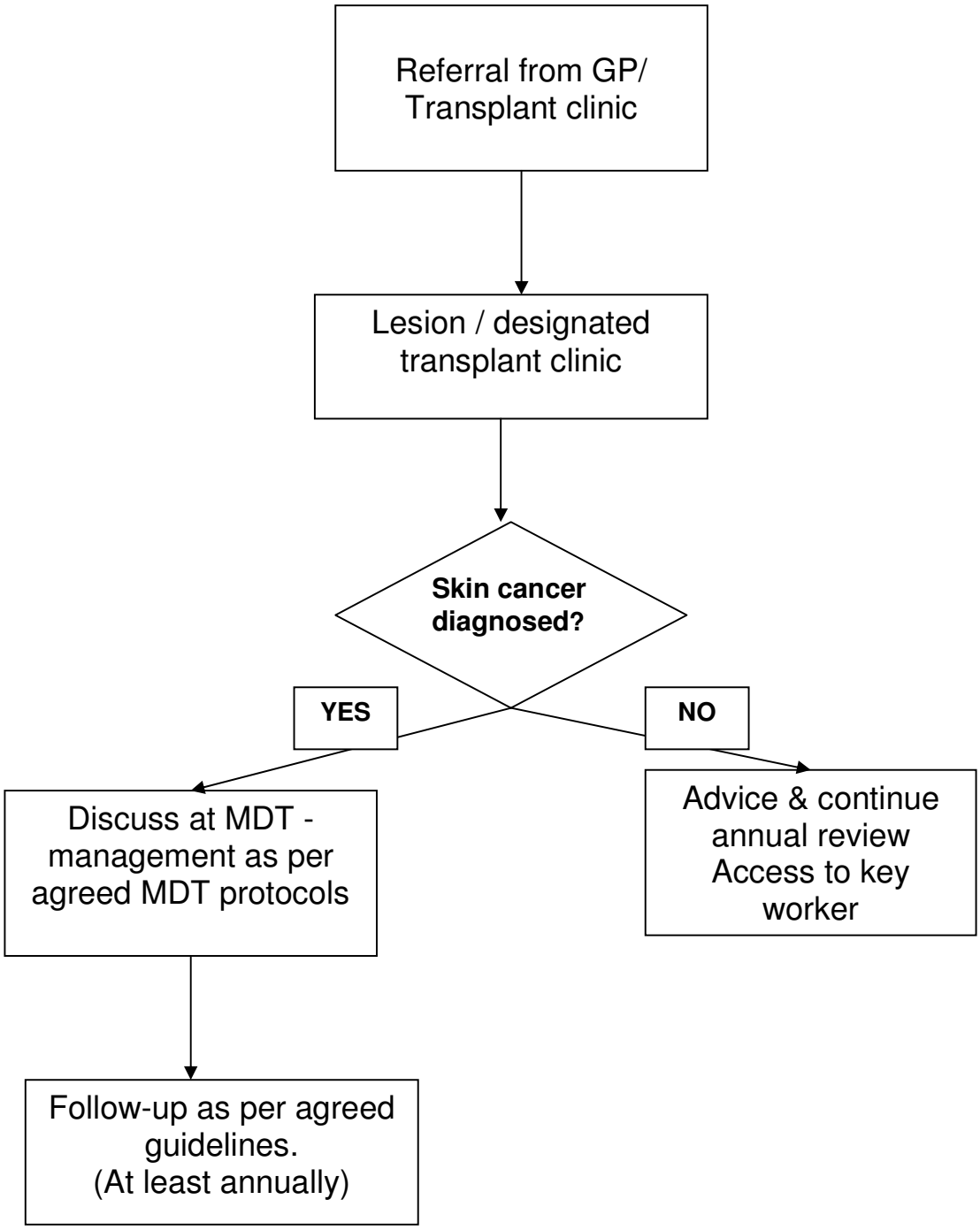
Royal Wolverhampton Hospitals (RWH) also has dedicated clinics for renal patients.

Dudley Group of Hospitals NHS Foundation Trust (DGOH) has dedicated clinic slots in their dermatology Clinics for transplant patients

Shrewsbury & Telford Hospital (SaTH) does not have any dedicated clinics; patients are seen within the Dermatology clinics
A register of patients is kept by the Clinical Nurse Specialist, to ensure that all patients have at least an annual review and rapid access back into a clinic, if necessary.

The NSSG is aware that arrangements for other types of immunocompromised patients, with skin cancer, are not identified.
This issue will be included as an action within the Skin NSSG Work Plan for 2010/2011; which is in the process of being developed.

GMCN Transplant patient care pathway



Arrangements for Skin Cancer in Specific Anatomical Sites
Location of Named MDTs 2009

Trust	08-1A-212j Head & Neck	08-1A-213j Colorectal	08-1A-214j Gynaecology	08-1A-215j Urology	08-1A-216j Haemato – oncology	08-1A-217j Sarcoma
DGOH	Head & Neck Local MDT and then Local Skin MDT	Colorectal Local MDT and Local Skin MDT	Gynaecology Local MDT and Local Skin MDT	Urology Local MDT and Local Skin MDT	Haemato-oncology Local MDT and Local Skin MDT	Local Skin MDT
MSFT	Head & Neck Local MDT and then Local Skin MDT	Colorectal Local MDT and Local Skin MDT	Gynaecology Local MDT and Local Skin MDT	Urology Local MDT and Local Skin MDT	Haemato-oncology Local MDT and Local Skin MDT	Local Skin MDT
RJAH						Local Sarcoma MDT
RWH	Head & Neck Local MDT and then Local Skin MDT	Colorectal Local MDT and Local Skin MDT	Gynaecology Local MDT and Local Skin MDT	Urology Local MDT and Local Skin MDT	Haemato-oncology Local MDT and Local Skin MDT	Local Skin MDT
SaTH	Head & Neck Local MDT and then Local Skin MDT	Colorectal Local MDT and Local Skin MDT	Gynaecology Local MDT and Local Skin MDT	Urology Local MDT and Local Skin MDT	Haemato-oncology Local MDT and Local Skin MDT	Local Skin MDT
UHNS	Head & Neck Local MDT and then Local Skin MDT	Colorectal Local MDT and Local Skin MDT	Gynaecology Local MDT and Local Skin MDT	Urology Local MDT and Local Skin MDT	Haemato-oncology Local MDT and Local Skin MDT	Local Skin MDT

Measure 08-1A-212j

Skin Cancer NSSG Guidelines for Head and Neck Skin Cancer

Malignant Melanoma

All cutaneous malignant melanoma, including any arising in periocular skin, should be discussed primarily at the Skin MDT.
If excision of a melanoma is likely to encroach on a mucocutaneous junction (nasal, auricular canal, conjunctiva) then this should be discussed in the Skin MDT but also with a member of the Head and Neck MDT.
Melanomas only revealed histologically as such after excision by member of Head and Neck MDT may be discussed principally in that MDT, but should also be discussed at the Skin MDT (for considerations including trial eligibility, general skin examination).

Mucosal (nasal, ocular, periocular) Melanomas / Other tumours

These should be discussed primarily at the Head and Neck MDT with secondary discussion at the Skin MDT, (for considerations including trial eligibility, general skin examination for Melanoma and SCC).

Ocular Melanomas

These should be discussed primarily at the Head and Neck MDT with input from the Ophthalmic surgical team and secondary discussion at the Skin MDT, (for consideration of trial eligibility and general skin examination).

Periocular Melanomas / Other tumours

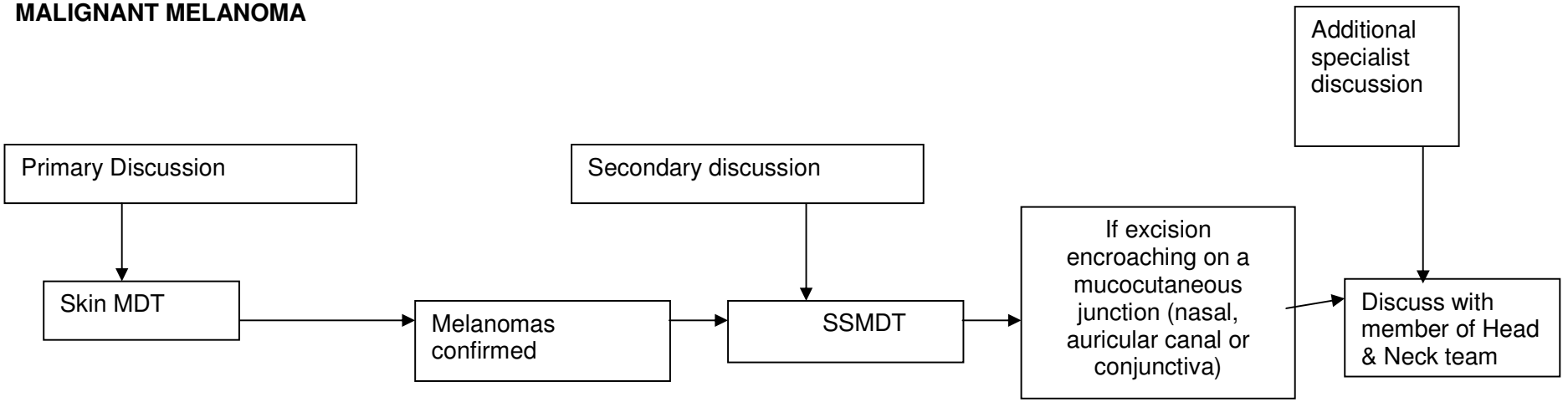
These should be discussed primarily at the Head and Neck MDT with input from the Oculoplastic surgical team and secondary discussion at the Skin MDT, (for considerations including trial eligibility and general skin examination for melanoma and SCC).

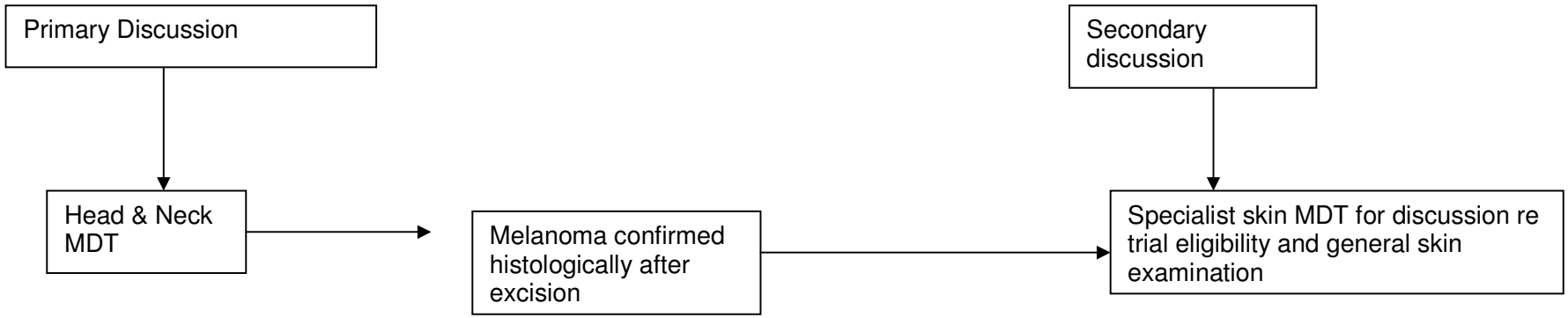
Squamous Carcinoma and Basal Cell Carcinoma

Peri-ocular basal cell and auricular nasal carcinomas may be discussed primarily at the Skin Meeting or Head and Neck Meeting. Other basal cell carcinomas should be discussed primarily at the Skin Meeting.

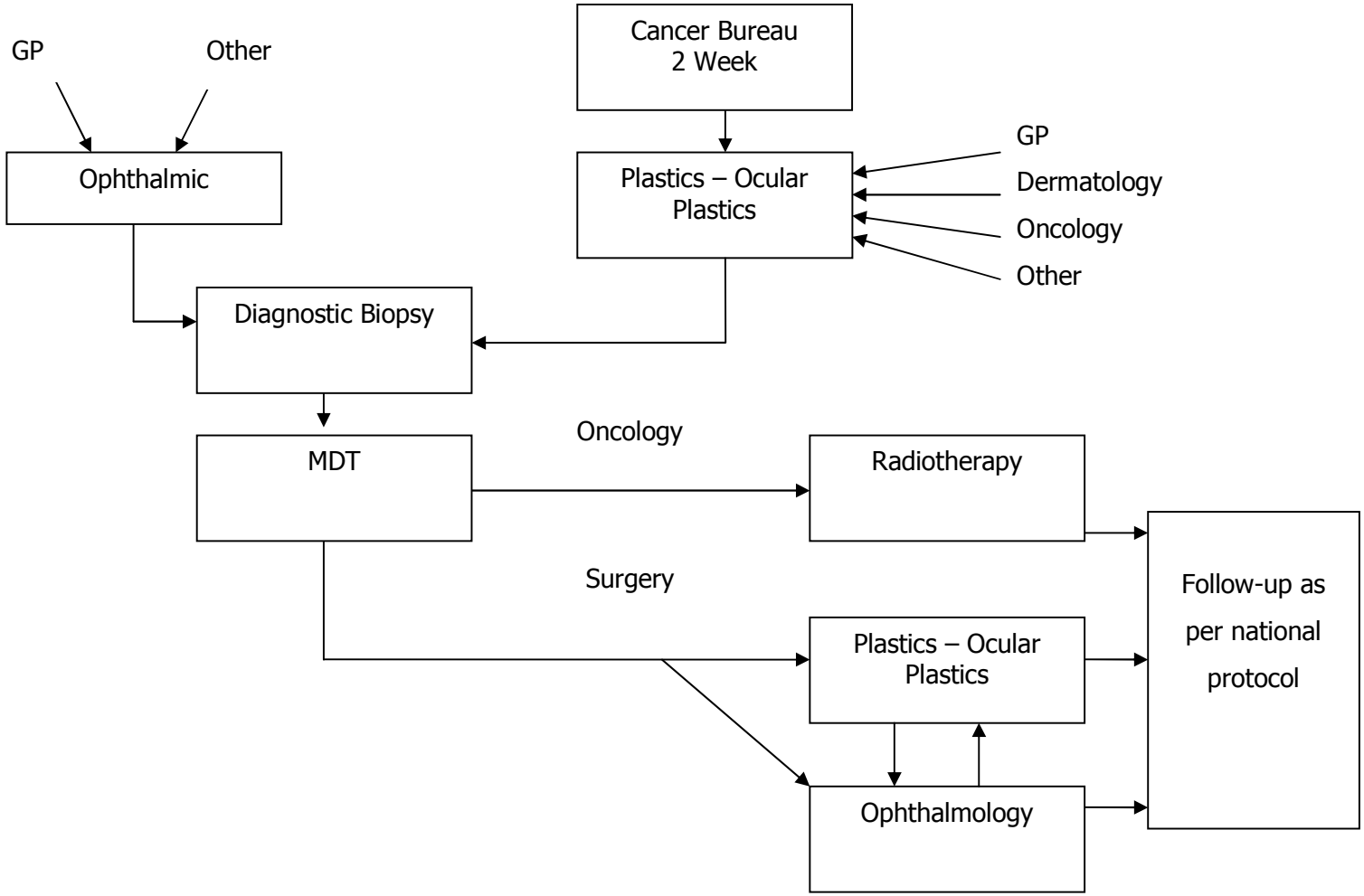
Skin Cancer NSSG Pathway for Head & Neck Skin Cancer

MALIGNANT MELANOMA





MUCOSAL & OCULAR MELANOMA AND SCC



Measure 08-1A-213j

Skin Cancer NSSG Guidelines for Anal and Perianal cancer

General Tenet

The Skin Cancer MDT reviews and takes the lead in all skin cancer cases where planned excision of a skin cancer will not encroach on the anal canal mucosa.
This is compatible with and complimentary to the GMCN Colorectal guidelines.
There is a nominated plastic surgeon affiliated to the regional Colorectal MDT for cases requiring reconstruction; who is a member of the GMCN Skin NSSG.

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

Guidelines as for the general tenet stated above for any excision.

In addition, any melanoma arising in the anal canal or anal margin, and dealt with by a colorectal surgeon with principle discussion at the colorectal MDT, should also be discussed secondarily at the Skin MDT, where issues including trial eligibility and general skin examination can be reviewed.

BOWENS DISEASE

Guidelines as for the general tenet stated above for any excision.

For Bowen's disease encroaching on the perianal skin (but not the anal canal), considered treatable by non-surgical therapy (e.g. cryotherapy, efudix or aldara cream) may be treated by a member of the Skin MDT and discussed at the Skin MDT.
Examinations / Investigations to exclude invasive urogenital / anorectal cancer.
May need involvement of Colorectal/ Urological / Gynae.MDT as clinically appropriate.

PERIANAL PAGET'S DISEASE

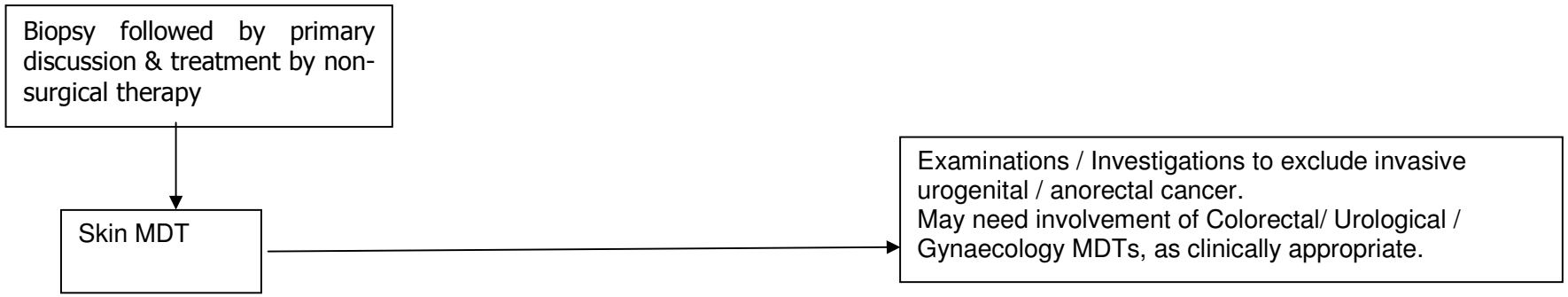
Guidelines as for the general tenet stated above for any excision.

If presenting to a member or the Skin MDT, treatment will be led by that person, with discussion principally at the Skin MDT. However collaboration with a colorectal MDT member is required to ensure no internal invasive cancer or Paget's involvement of anal canal.

Skin Cancer pathway for Skin Cancer of Anal & Perianal

MALIGNANT MELANOMA and SCC

BOWENS DISEASE AND PAGET'S ENCROACHING ON THE PERIANAL SKIN (BUT NOT THE ANAL CANAL)



Measure 08-1A-214j

Skin Cancer NSSG Guidelines for Skin Cancer of External Female Genitalia

General Tenet

The Gynae Cancer MDT reviews and takes the lead in all **invasive non melanoma skin cancer** cases, involving female genitalia.

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

Guidelines as for general tenet stated above, for any excision.
In addition, any melanoma arising in the female genitalia, and dealt with by a gynaecological surgeon with principle discussion at the Gynaecological Cancer MDT, should also be discussed secondarily at the Skin MDT; where issues including trial eligibility and general skin examination can be reviewed.

IN-SITU SQUAMOUS DISEASE

Guidelines as for general tenet stated above for any excision.

Bowen's disease on the labia majora, considered treatable by non-surgical therapy should be treated by a member of the Skin MDT.
However biopsy is mandatory to exclude other pathologies (Paget's disease, invasive neoplasia).
Furthermore unless there is Bowen's disease elsewhere in traditionally sun-protected skin sites, collaboration with a member of the Gynaecological MDT is recommended, to exclude labia minora VIN (vulval intraepithelial neoplasia), and VAIN (vaginal intraepithelial neoplasia).

Bowenoid papulosis – this should be treated primarily by a member of the Skin MDT.
However, as this confers increased risk of cervical neoplasia, gynaecological referral for advice on possible cervical pathology is recommended.

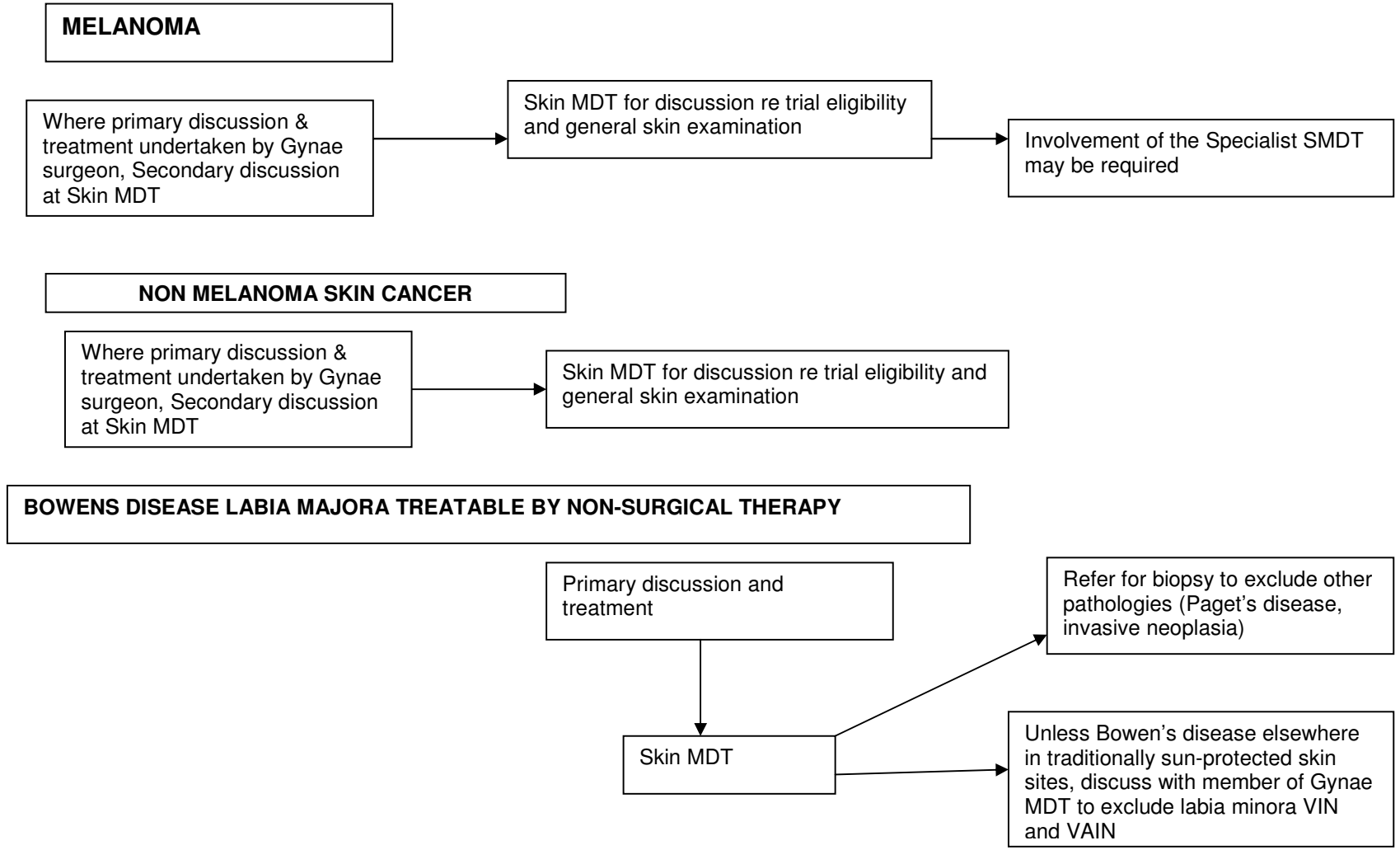
VIN involving labia minora- this should be referred to a member of the Gynaecological MDT.

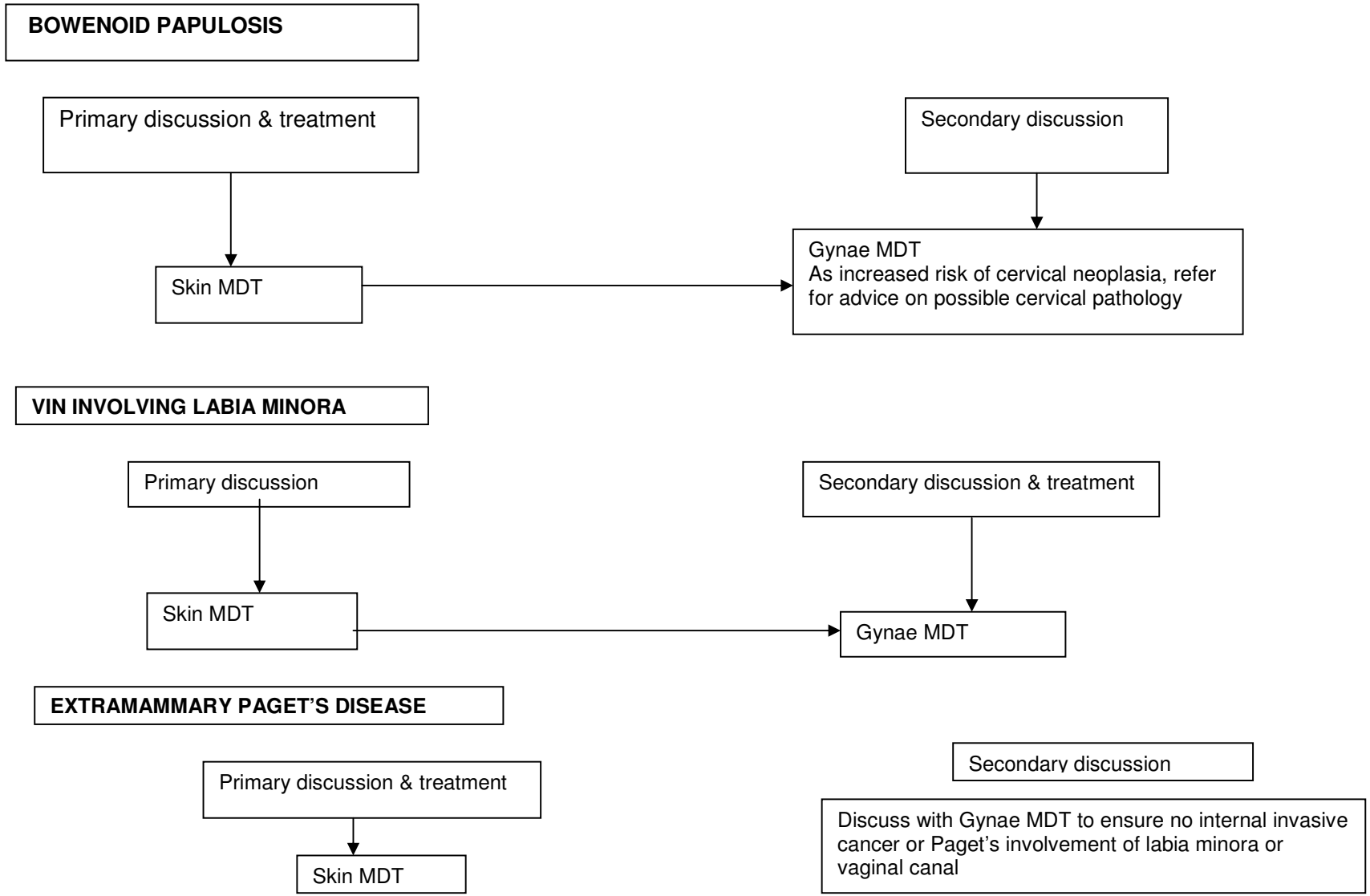
EXTRAMMARY PAGET'S DISEASE

Guidelines as for the general tenet stated above for any excision.

If presenting to a member or the Skin MDT, treatment will be led by that person, with discussion principally at the Skin MDT.
However collaboration with a Gynaecological MDT member is required to ensure no internal invasive cancer or Paget's involvement of labia minora or vagina canal.

Skin Cancer NSSG Pathway for Skin Cancer of External Female Genitalia




BOWENOID PAPULOSIS
Primary discussion & treatment
Skin MDT
Secondary discussion
Gynae MDT
As increased risk of cervical neoplasia, refer for advice on possible cervical pathology
VIN INVOLVING LABIA MINORA
Primary discussion
Skin MDT
Secondary discussion & treatment
Gynae MDT
EXTRAMAMMARY PAGET'S DISEASE
Primary discussion & treatment
Skin MDT
Secondary discussion
Discuss with Gynae MDT to ensure no internal invasive cancer or Paget's involvement of labia minora or vaginal canal

Measure 08-1A-215j

Skin Cancer NSSG Guidelines for External Male Genitalia

General Tenet

The Urology Cancer MDT reviews and takes the lead in all **invasive non melanoma skin cancer** cases, involving male genitalia.

Specific Situations

Certain tumour types have additional guidelines:

MELANOMA

Guidelines as for the general tenet stated above for any excision.

In addition, any melanoma arising in the male urethra, and dealt with by a urological surgeon with principle discussion at the Urology Cancer MDT, should also be discussed secondarily at the Skin MDT; where issues including trial eligibility and general skin examination can be reviewed.

IN-SITU SQUAMOUS DISEASE

Guidelines as for the general tenet stated above for any excision.

Bowen's disease, Bowenoid papulosis; diagnosed by a member of the Skin MDT are discussed at the Skin MDT. These cases are then referred onto the Urology MDT; shared care may be an agreed option for these patients

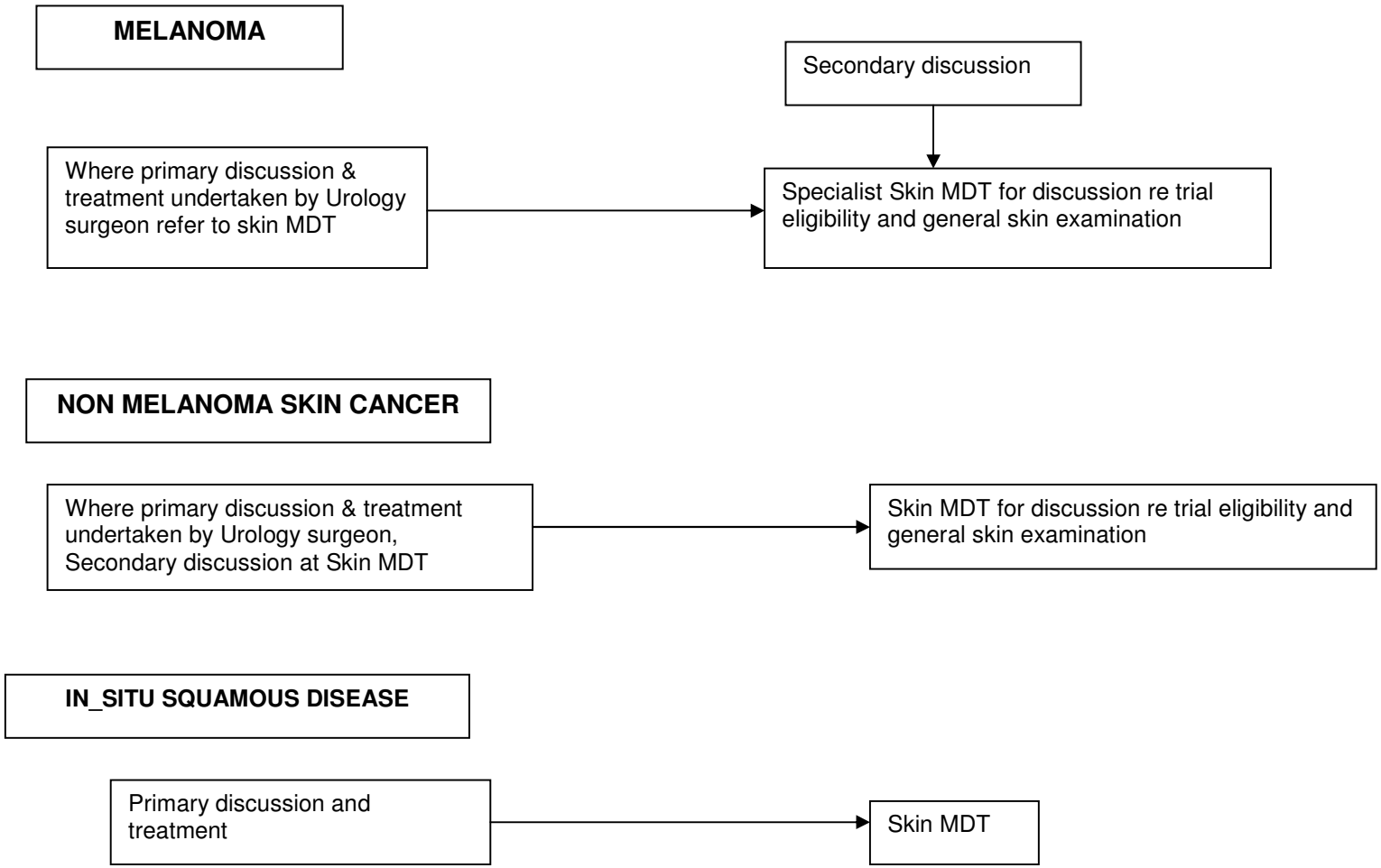
Erythroplasia of the glans; diagnosed by a member of the Skin MDT are discussed at the Skin MDT. These cases are then referred onto the Urology MDT; shared care may be an agreed option for these patients

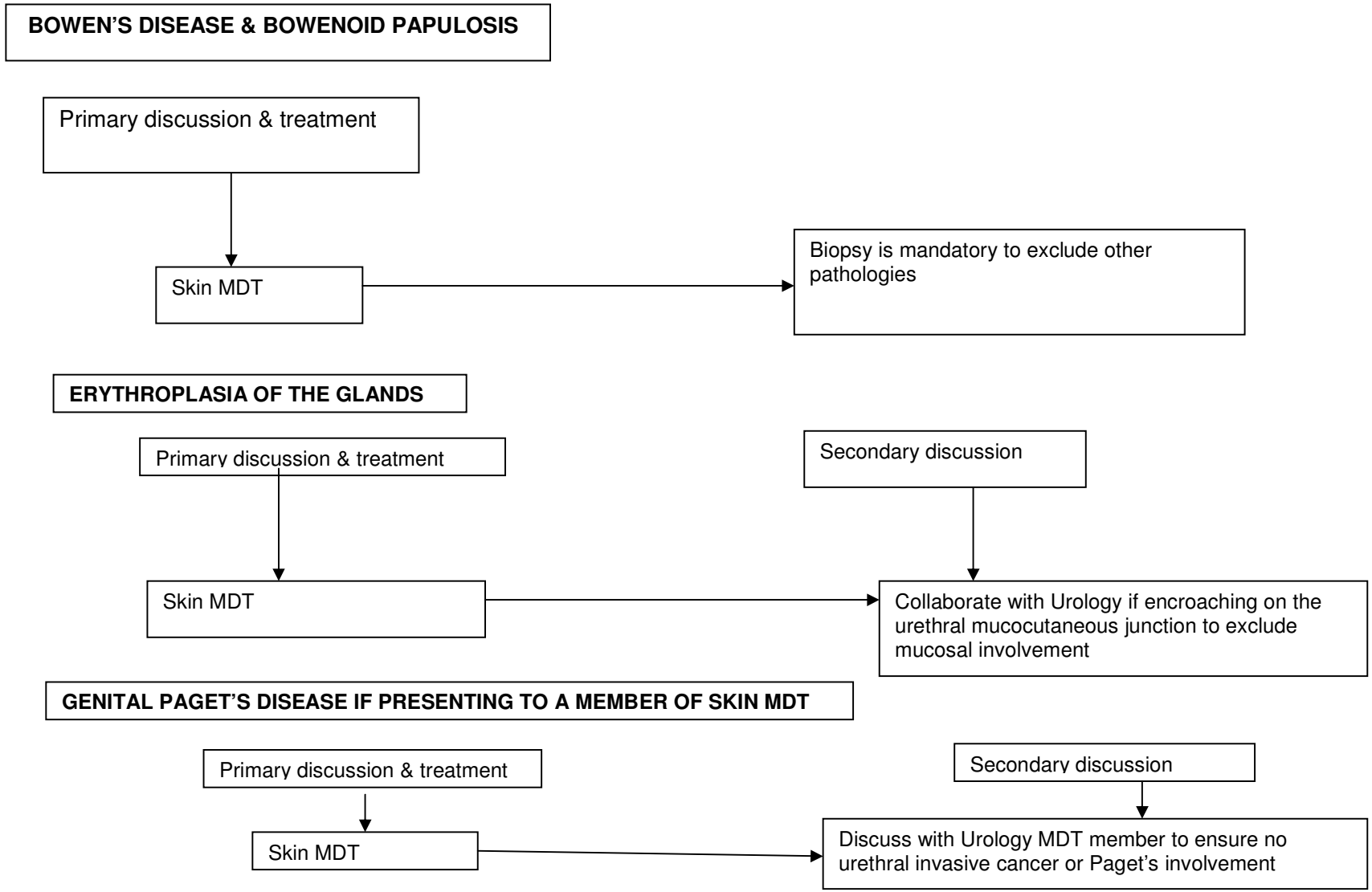
PAGET'S DISEASE

Guidelines as for the general tenet stated above for any excision.

If presenting to a member or the Skin MDT, treatment will be led by that person, with discussion principally at the Skin MDT.
However collaboration with a Urological MDT member is required to ensure no urethral invasive cancer or Paget's involvement.

Skin Cancer NSSG Pathway for Skin Cancer of External Male Genitalia




BOWEN'S DISEASE & BOWENOID PAPULOSIS
Primary discussion & treatment
Skin MDT
Biopsy is mandatory to exclude other pathologies
ERYTHROPLASIA OF THE GLANDS
Primary discussion & treatment
Secondary discussion
Skin MDT
Collaborate with Urology if encroaching on the urethral mucocutaneous junction to exclude mucosal involvement
GENITAL PAGET'S DISEASE IF PRESENTING TO A MEMBER OF SKIN MDT
Primary discussion & treatment
Secondary discussion
Skin MDT
Discuss with Urology MDT member to ensure no urethral invasive cancer or Paget's involvement

Measure 08-1A-209j, 210j and 216j

Skin Cancer NSSG Guidelines for Skin Lymphoma

Cases of lymphoma presenting in the skin should be investigated locally and discussed at the local Skin MDT (LSMDT) and local Haemato-Oncology MDT (HOLMDT) in order to determine presence of absence of systemic involvement.
Investigations will usually comprise skin biopsy histology, immunoflourescence, and PCR clonality assay; blood tests (usually FBC, LFTs, U&Es, ESR, LDH, lymphocyte subset analysis, lymphocyte clonality, and for B lymphomas immunoglobulins, serum and urine electrophoresis; where appropriate HTLV1 serology; bone marrow aspirate and trephine, and CT chest, abdomen and pelvis.

Systemic/nodal lymphomas presenting in the skin remain under the management discretion of the HOLMDT.

Primary cutaneous B cell lymphoma may be treated locally by a member of the HOLMDT, but the Supra Network Lymphoma Multidisciplinary Team (SNLMDT) may be notified.

Primary cutaneous T lymphoma may be referred to the Supra Network Lymphoma Multidisciplinary Team (SNLMDT) as below:

Mycosis fungoides

Mycosis fungoides, stage 2b and below should be discussed and managed at local skin cancer MDT.

The Supra Network MDT may request that radiotherapy or chemotherapy or further/repeat investigation be administered at the local hospital as shared care.

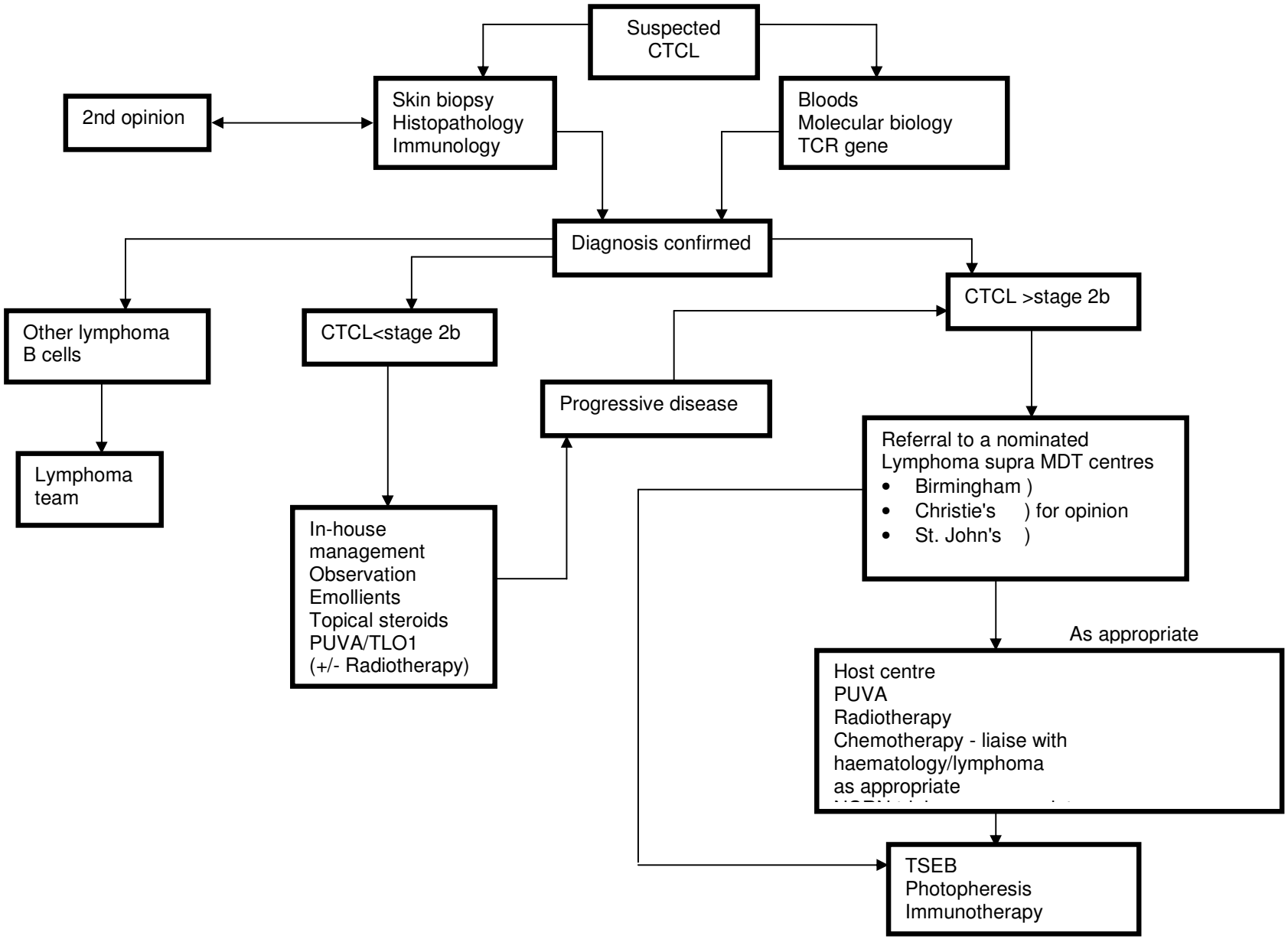
All referrals should include results of any immunophenotyping and clonality studies.

For mycosis fungoides of stage 2b and above, treatment options, including consideration of TSEB and photopheresis will be determined by the nominated Supra Network Lymphoma MDT. Referral for TSEB is to University Hospitals Coventry & Warwickshire; referral for photopheresis is to either Rotherham or London

PUVA, radiotherapy, and other chemotherapy will usually be given at the local referring hospital.

Cutaneous lymphomas other than Mycosis fungoides

Lymphomatoid papulosis may be discussed at and managed by a member of the Skin MDT. Where any clinical doubt exists as to the diagnosis, this should be referred to the HOLMDT for work-up as for CD30+ve lymphoma. CD30+ve and other lymphomas should be discussed at and managed by the HOLMDT. Referral may then be made to the SNLMDT


Suspected CTCL
2nd opinion
Skin biopsy
Histopathology
Immunology
Bloods
Molecular biology
TCR gene
Diagnosis confirmed
Other lymphoma
B cells
Lymphoma team
CTCL<stage 2b
In-house management
Observation
Emollients
Topical steroids
PUVA/TLO1
(+/- Radiotherapy)
Progressive disease
CTCL >stage 2b
Referral to a nominated Lymphoma supra MDT centres
Birmingham)
Christie's) for opinion
St. John's)
As appropriate
Host centre
PUVA
Radiotherapy
Chemotherapy - liaise with haematology/lymphoma as appropriate
TSEB
Photopheresis
Immunotherapy

Measure 08-1A-217j

Skin Cancer NSSG Arrangements for Sarcoma

Superficial e.g. Dermatofibrosarcoma Protuberans (DFSP) (excludes AFX)

These may be discussed at and managed by the LSMDT; but may be referred onto either of the two Supra Network Sarcoma MDTs which support this Network – Royal Orthopaedic Hospital Sarcoma MDT (ROHSMDT) or Greater Manchester and Oswestry Sarcoma Service (GMOSS).

The Network Skin MDTs will notify all cases of recurrence to either of the two Supra Network Sarcoma MDTs.

Deep

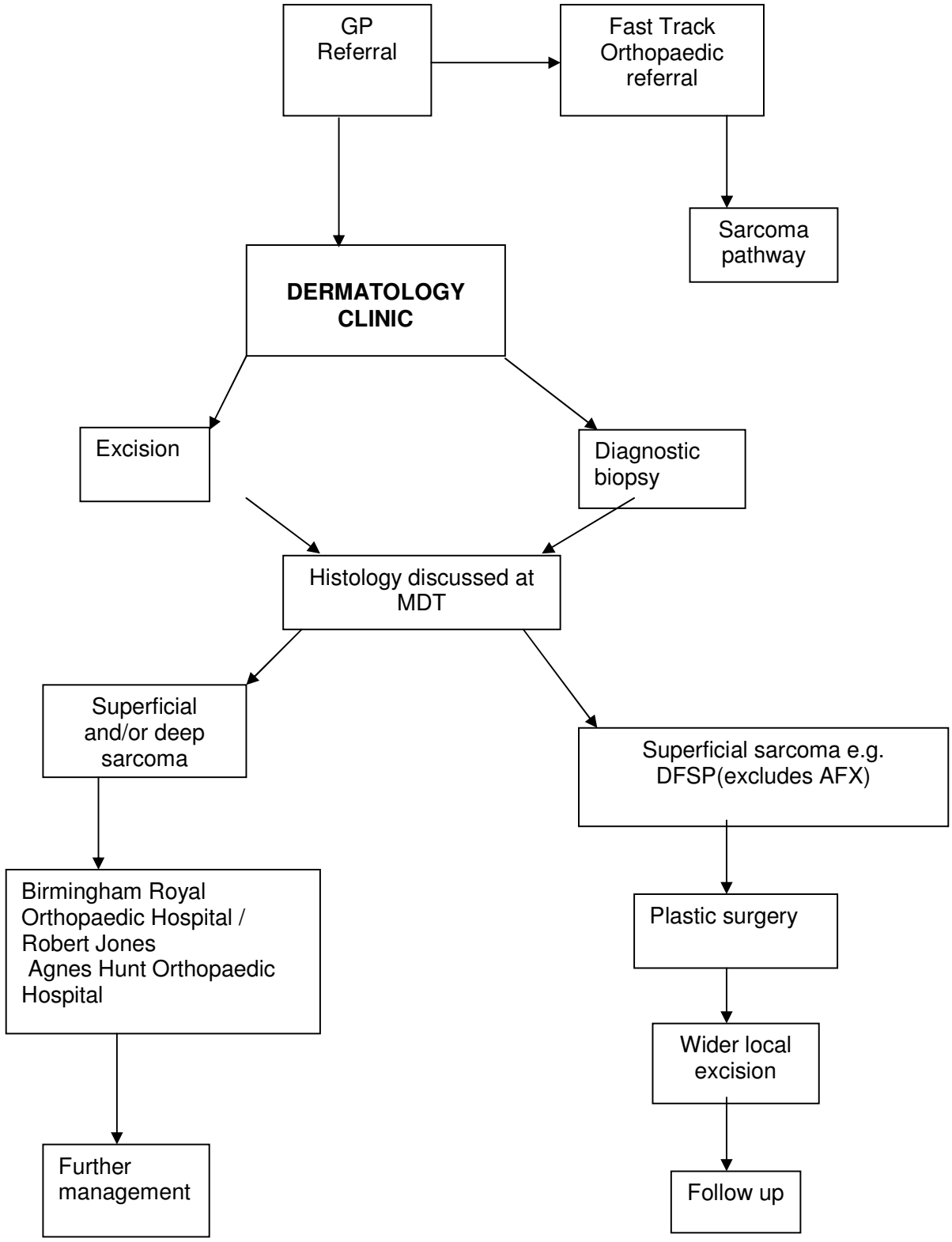
Deep seated lesions are occasionally picked up by the local Skin MDT. In all cases these would be referred onto ROHSMDT or GMOSS.

Angiosarcoma

The Network Skin MDTs will notify all cases of angiosarcoma, to either of the two Supra Network Sarcoma MDTs.

Greater Midlands Cancer Network
Skin Network Site Specific Group

SKIN SARCOMA PATHWAY



Greater Midlands Cancer Network
Skin Network Site Specific Group

GMCN Primary Care Referral Guidelines for Skin Cancer Measure 08-1C 113j

This document outlines the referral processes for patients with suspected Skin Cancer across the Greater Midlands Cancer Network (GMCN). Guidelines incorporate agreed Network criteria for referral of suspected cancer in line with NICE Guidance – Referral Guidelines for Suspected Cancer (revised 2005).
Referrals outside of the urgent suspected cancer route are part of the *Choose and Book* policy.
The table below provides details of contact points for referral. It should be noted that this information relates to adult services in line with Improving Outcomes Guidance.
Specialist children's services are provided at tertiary centre in Birmingham

Designated Hospital	Name of Trust	Skin Lead	Contact point
City General Site	University Hospital of North Staffordshire NHS Trust	Mr Sukh Rayatt	01782 552813
Royal Shrewsbury Hospital	Shrewsbury & Telford Hospital NHS Trust	Dr Susan Kelly	01743 261333
Stafford Hospital	Mid Staffordshire NHS Foundation Trust	Dr Eleanor Lochee - Bayne	01543 576034
New Cross Hospital	Royal Wolverhampton Hospitals NHS Trust	Dr Simone Oliwiecki	01902 695079
Russells Hall Hospital	Dudley Group of Hospitals NHS Foundation Trust	Dr Graeme Stewart	01384 244082

Referral Guidelines for Primary Care
The Skin Cancer Network Site Specific Group (NSSG) in consultation with the Primary Care Trusts (PCTs) has agreed referral guidelines for GPs in line with the agreed GMCN community models; the guidelines are:

- Actinic Keratoses and precancerous lesions may be dealt with by any GP.
- All cases of suspected Squamous cell Carcinomas and Melanomas should be referred via the 2 week referral form
- GPs should refer suspected cases of skin cancer (requiring treatment, including Basal Cell Carcinomas (BCCs), to the contact point of the relevant named MDTs (table above), or for cases of low risk BCC there is the option of referral to the contact point of a relevant GPwSI-based service

Advanced Primary Care Service Shropshire Locality

Shropshire County PCT	***GPwSI***	***Practice***	***Contact number***
	Simon Reid	Shrewsbury Dental Spa	07525212699 01743 343433
	Jamie Muir	Marysville Medical Practice	01743 276000
	Alun Lovell	Llanfyllin Medical Practice	01691 648054
Telford & Wrekin PCT	***GPwSI***	***Practice***	***Contact number***
	Trevor Williams	Oakengates Medical Practice	01952 615120
	Jacqui Orledge	Albrighton Medical Practice	01902 372301
	Sandy Hallatt	South Hermitage Medical Practice	01743 343148

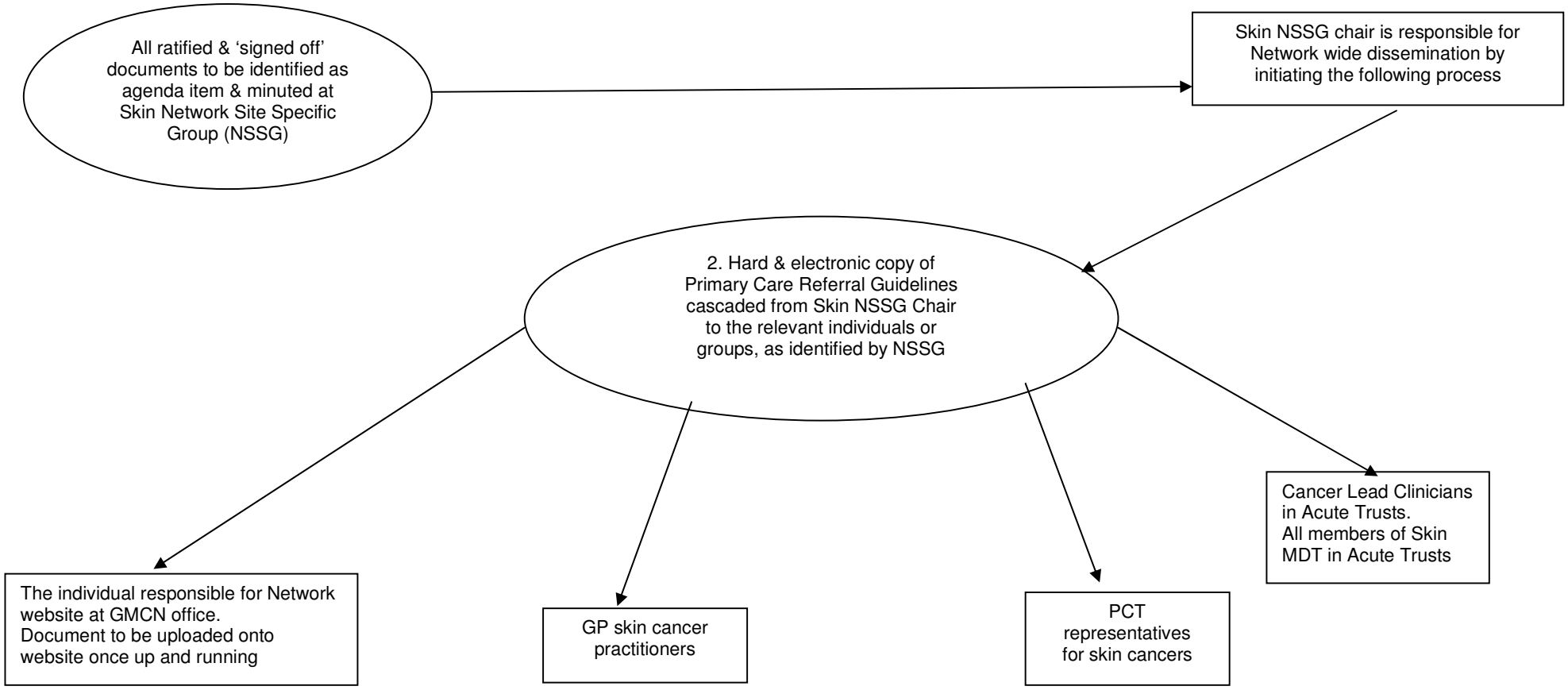
Guidance for GPs on identifying potential high risk BCCs

Clinical features of BCCs at high risk of recurrence (any one of these):
- **Site**: Face, scalp, ears or,
- **Size**: 2cms or more or,
- **Circumstances** – immunocompromised patient, genetically predisposed patients (e.g. Gorlins Syndrome), previously treated lesion, flat lesion, hard thickened skin (appearance of morphoeic BCC)

For the purpose of GP referral, "low risk BCC" is considered to be any BCC, other than those above.

These guidelines are underpinned by an assumption that GPs will not knowingly treat patients beyond their remit. This is monitored by MDTs and PCTs.

Distribution Policy
The Chair of the Skin NSSG, via the Network Office, will distribute the Primary Care Referral Guidelines to the appropriate PCT representatives after any annual update. The guidelienes will also be available on the GMCN Website.



Appendix 6 Measure: 08 1C 114j

Mohs Surgery

The named Hospital Practitioners, which the Network authorises as the only Practitioners to carry out Mohs surgery; each with their individual averaged case numbers.

To be agreed by Chair of Skin NSSG and GMCN Network Board

Hospital Practitioner	2007	2008	2009 (Jan – June)
Dr J. Marsden	59	63	34
Dr I. Zaki	136	144	76
Dr P. Preston	-	(Aug – Dec 08) 21	28

Vivek Mudaliar
Chair, Skin NSSG
Greater Midlands Cancer Network

20th January 2010

Appendix 7 Measure: 08 1C 102j

Department of Obstetrics & Gynaecology

Consultant: Mr D J Murphy **Secretary: Penelope Jukes** **Tel: 01902-695150**

18 February 2010 DJM/PJ

Dr V Mudaliar
Consultant Pathologist
Royal Shrewsbury Hospital
SHREWSBURY
SY3 8XQ

Dear Vivek

Thank you very much for meeting me last Friday to discuss the progress of the Skin NSSG under your chairmanship. Over the last year, we are both agreed that the NSSG has made great strides towards completion of the peer review process and the establishment of the specialist MDTs in Stoke and Wolverhampton/Dudley. Obviously the impending peer review visit is taking centre stage in terms of the preparation time needed by both yourself and other members of the NSSG, but we are both hopefully that following the visit we can move on to a more active work programme for the next twelve months.

I am in agreement with you that we need to closely monitor the progress of the specialist MDTs on the two sites and be assured that the configuration we have for the Greater Midlands Cancer Network is appropriate and fit for purpose. I am happy that you are continuing in the role for the foreseeable future and I would hope that we could make considerable progress with the Skin MDT over the next twelve month.

Kind regards,

Yours sincerely

Damian J Murphy
Clinical Director
Greater Midlands Cancer Network